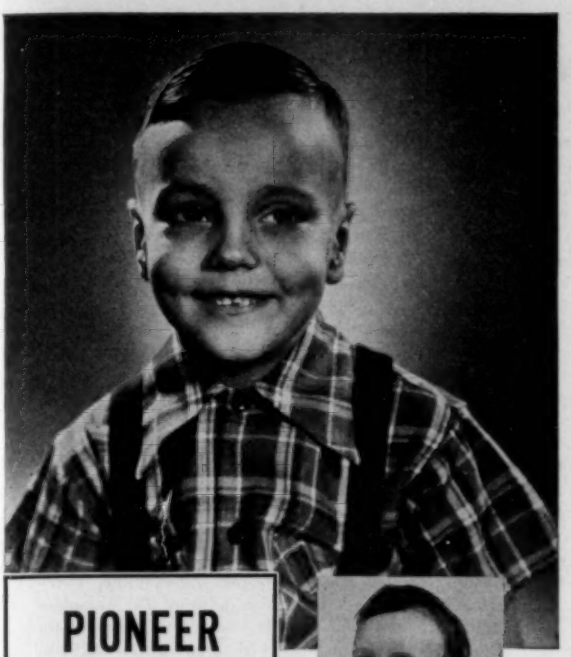


PIONEER MEAT EATER

(5 years later)

Bill Purvy at one year. He became a participant in Swift's first meat-feeding test at 4½ months.

Current Clinical Meat Feeding Studies

REPORT No. 4

EFFECT OF MEAT IN THE DIET OF INFANTS AND YOUNG CHILDREN

Results of this study indicate that meat promotes hemoglobin and erythrocyte formation. These findings were revealed in a preliminary report published in the J.A.M.A. (134 1215 (1947). The present studies are a continuation of the work reported in this article.

This study is part of an extensive clinical research program now being conducted through grants-in-aid made by Swift's.

Long before Swift's Meats for Babies were available generally, little Bill Purvy was eating them every day. He started at 4½ months. That was over five years ago—during Swift's original meat-feeding tests. Before the development of Swift's Meats for Babies, the customary age to start meat was at least *six* or *nine* months. And because home preparation was so complicated, most babies simply did without!

"He's a healthy boy"

Says Bill's mother, and it's evident from the picture of Bill above. His mother reports that he liked Swift's Meats for Babies from the beginning.

Today any baby can have the same right start in life that Bill had. Doctors now recommend Swift's Meats for Babies in the early weeks of life — to provide the complete, high-quality proteins and iron every infant needs every day.

Swift's appetizing variety includes: beef, lamb, pork, veal, liver and heart—to help infants acquire a taste for variety and form sound eating habits.

Swift's Meats for Babies are trimmed and cooked expertly—to minimize fat content and preserve a maximum of nutrients. They're convenient—ready to serve!

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

SWIFT

...foremost name in meats

...first to develop and clinically test 100% Meats for Babies

Between Ourselves

Three separate accounts of the provision that is made for supervising the health of our **Indian population** are featured in this issue. They make very easy reading since they show the human interest side of the service so clearly. Readers should realize, however, that there are thousands of Indians living close to the more heavily populated areas too. They perhaps appear less romantic than those in the northern areas, being much less nomadic.

According to the best available estimates, before the white man came to what is now known as Canada there were something over 200,000 Indians. Though the present population figure is considerably below that number, the popularly-held opinion that the race is disappearing is not in accordance with facts. During the 20th century the trend has been upward with a gradual but fairly steady increase. Much of the credit for this improvement can be given to the health programs that have been sponsored by the Federal Government. Several hospitals are maintained by the Indian Affairs Branch for the exclusive use of the Indians. In addition, provision is made for their hospitalization in municipal hospitals in many areas.

Reference is made in the stories we have included here to "Treaty" moneys. Perhaps some of our readers are not aware of the derivation of this term. In the older, more thickly settled parts of Canada—Ontario, Quebec, and the Maritimes—the history of the Indians has been one of slow development with that of the communities near which their reserves were located. In Western Canada, the situation has been different. There, the rapid spread of civilization necessitated prompt and effective measures to protect the rights and privileges of the Indians. Treaties were made with the various tribes whereby the Indians ceded to the Crown their aboriginal title and interest in the land. In consideration of this cession, the Federal Government promised certain benefits: adequate territory set aside as Indian reservations; cash grants made; annual payment of annuities on a per capita basis—the "Treaty" money; assistance in agriculture, stock-raising, hunting, trapping, etc.; the education of Indian children; facilities for health protection. No treaty has been made with the Indians of British Columbia, except in the Peace River Block, but their welfare has received no less attention.

The Indian Act provides for the enfranchisement of Indians. However, when an Indian is enfranchised he ceases to be an Indian under the law and acquires the full status of Canadian citizenship. This loss of special protection under the Indian Act has been a curb to the general practice of seeking enfranchisement.

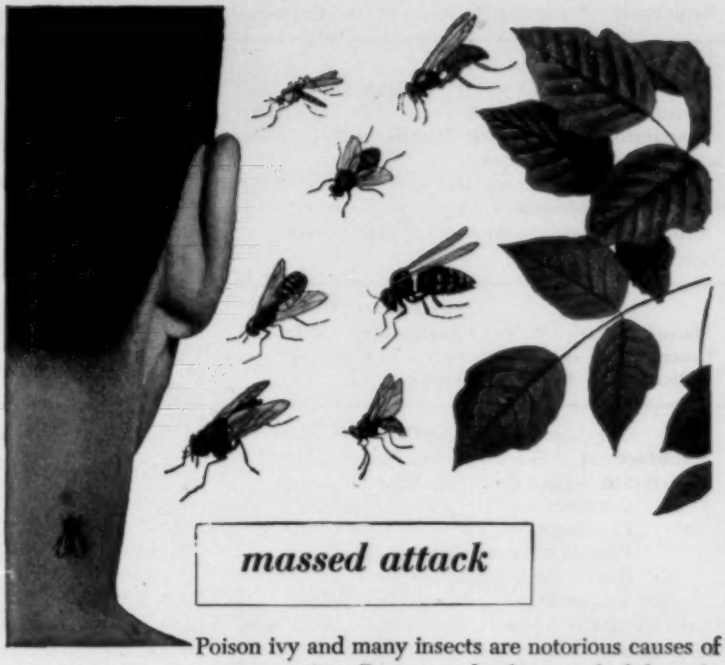
* * *

Recently, a letter came to us from a nurse who has been a regular subscriber to the *Journal* ever since her graduation in 1912. This past year while working on her thesis for her master's degree, she examined every issue since the first number of *The Canadian Nurse* was published in 1905, searching for material dealing with organization and administration. Since you, the nurses of Canada, have been responsible for the calibre of the material that has been published through the thousands of painstakingly prepared articles you have contributed, we want to pass on to you the compliments paid by this authority: "I feel that Canadian nurses have made a large contribution to literature in nursing, especially in the therapy area. I have been impressed by the number of American nurses who use this magazine and value its contents. In addition to the many fine articles, I have gleaned much information from the book reviews and from your advertisers' columns. While in India as a missionary . . . I found these two sources of particular help in keeping up with the new publications and new items of equipment."

* * *

This issue contains the last of three instalments of Sub-Inspector Carl Ledoux' interesting and different article, **"The Nurse and the Law."** If you did not receive the June and July issues containing the rest of this account, write in for your copies. Single copies sell for 25 cents each. Send the money with your order, please.

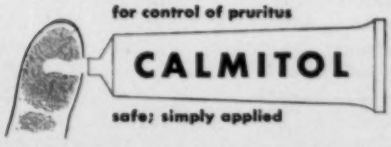
Some people speak from experience; others, from experience, don't speak.



massed attack

Poison ivy and many insects are notorious causes of severe pruritus. Prompt and safe control of the itching is a prime therapeutic need, for the patient's scratching or self-medication can lead to serious sequelae.

Calmitol Ointment gives relief directly upon application. It may be used liberally and repeatedly without the risk of exacerbation, for Calmitol Ointment is free from dangerous drugs such as phenol (as in calamine with phenol), cocaine and cocaine derivatives.



Active ingredients:
Camphorated chloral
Hyoscyamine oleate
Menthol

The Leeming Miles Co. Ltd. 1 *Notre Dame St., W., Montreal, Canada*

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

DANILONE

Manufacturer — Charles E. Frosst & Co., Montreal.

Description — Each tablet contains 50 mg. of Danilone (Frosst brand of Phenylindanedione) a new anticoagulant.

Indications — For prophylaxis and treatment of thromboembolism and thrombophlebitis. Has a latent period of action of about 24 hours and period of recovery of 48 hours.

Administration — Average initial dose, 1 tablet in morning and 2 tablets at night. Average maintenance dose, 1 tablet daily.

INOSITOL TABLETS

Manufacturer — Webber Pharmaceuticals, Toronto.

Description — Each tablet contains 250 mg. biologically active Inositol.

Indications — Hypercholesterolemia.

CADROSON Tablets

Manufacturer — Sharp & Dohme (Canada) Ltd., Toronto.

Description — Each six Cadroson Tablets contain:

Calcium	1.5 gm.
Phosphorus	0.75 gm.
Fluorine not more than	0.5 mg.
Iron	15.0 mg.
Vitamin D	1,000 U.S.P. units

Each six tablets represent the average minimal daily requirements of these nutrients during pregnancy and lactation, except fluorine for which no minimal requirement has been established.

Indications — Cadroson Tablets are indicated as a dietary supplement in the management of pregnant and lactating women and for the prophylaxis and management of dental caries. Administration of Cadroson Tablets helps to compensate for improper dietary habits of obstetric patients, to prevent depletion of maternal resources and development of rickets and dental caries in the infant.

AESCULIN

Manufacturer — Officinals of Canada, Lachine, Montreal 32.

Description — Formula 100 cc.:

Ext. Aesculus Hippocast. Sem. "Officine"	40.-
Ext. Hamamelis Virg. Fol. "Officine"	40.-
Sol. Glycero-hydroxy-ethylic. Citrat.	20.-

Indications — Hemorrhoids, phlebitis, varicose veins and similar vascular diseases.

Administration — 30 drops in water before each meal.

ANACOBIN

Manufacturer — British Drug Houses Ltd., Toronto.

Description — Each 1 cc. ampoule contains 15 micrograms crystalline vitamin B_{12} in saline solution.

Indications — Pernicious anemia and other hyperchronic macrocytic anemias.

Administration — Intramuscularly, 1 mcg. usually produces approximately the hemopoietic response of 1 unit liver extract.

the problem was

TO PROVIDE A NEUTRAL, SOLUBLE ANALGESIC IN TABLET FORM

The therapeutic advantages of the calcium salt of acetylsalicylic acid have been repeatedly stressed in the medical literature. Being an acid substance of low solubility, acetylsalicylic acid may act as a gastric irritant.

By contrast, pure calcium acetylsalicylate is highly soluble and is classified as a neutral salt, but it has its own defects. It is an unstable compound, and its presentation in a pure, stable and palatable form has challenged research workers for many years.

The difficult problem of the preparation of the calcium salt in stable and palatable form has at last been solved in DISPRIN.

DISPRIN has all the valuable properties of acetylsalicylic acid — analgesic, antipyretic and anti-rheumatic and, being soluble, it is more rapidly absorbed and consequently more speedy in its therapeutic effect. Thus DISPRIN embodies the virtues both of acetylsalicylic acid and of its calcium salt without any of the defects which hitherto have restricted the usefulness of these two preparations. DISPRIN rapidly dissolves in water to yield a solution which is substantially neutral, stable and palatable.

SOLUBLE, PALATABLE,
SUBSTANTIALLY NEUTRAL,
CALCIUM ACETYLSALICYLATE

RECKITT & COLMAN (CANADA) LIMITED
Pharmaceutical Division, Montreal

ZYMATINIC DROPS

Manufacturer — The Upjohn Company, Toronto.

Description — Each cc. contains:

Ferrous Gluconate	65 mg.
Thiamin Chloride	1 mg.
Riboflavin	1 mg.
Nicotinamide	8 mg.
Folic Acid	1 mg.
Alcohol — 1.5%	

Indications — For nutritional anemias of infants and children.

Administration — 1 to 2 cc. daily.

CAM-CELL TABLETS

Manufacturer — Webber Pharmaceuticals Ltd., Toronto.

Description — Sodium Carboxymethylcellulose 225 mg. and Magnesium Oxide 75 mg. in each tablet.

Indications — Peptic ulcer therapy to lower gastric acidity. Has prolonged effect with no adverse effects.

THEPTINE

Manufacturer — Smith Kline & French; Canadian distributors: The Leeming Miles Co. Ltd., Montreal.

Description — A liquid preparation containing Dexedrine Sulphate, Thiamine, Niacin, and Riboflavin.

Indications — A restorative for patients in whom mental depression and nutritional inadequacy manifest themselves as apathy, lethargy, and physical debility. It is particularly suitable for children, invalids, convalescents, and the aged.

Administration — Usually one teaspoonful (5 cc.) three times a day, although some patients may require larger doses for best results. It is important to note that Theptine should be taken immediately after meals. If this dosage time is faithfully observed, there should be no interference with appetite.

RUBRAMIN CAPSULES

Manufacturer — E. R. Squibb & Sons (Canada) Ltd., Montreal.

Description — Each capsule supplies 25 micrograms of vitamin B_{12} for oral administration.

Indications — Recent studies suggest that many cases of pernicious anemia and certain other macrocytic hyperchromic anemias respond favorably to oral use of B_{12} in large doses

Administration — Dosage varies greatly. Initial dose of 150 mcg. daily (6 capsules) is suggested. If, after a week or 10 days, the blood picture has not improved, dose should be increased to 300 mcg. daily. If not improved after 3 weeks, intensive parenteral B_{12} therapy should be started immediately. If improvement is shown on oral Rubramin, therapy should be continued until the blood picture reaches normal.

RONIACOL

Manufacturer — Hoffmann-La Roche Limited, Montreal.

Description — Peripheral vasodilator for oral administration. Each tablet contains approximately 50 mg. of tartaric acid salt of beta-pyridyl-carbinol (the alcohol corresponding to nicotinic acid). Longer lasting action than nicotinic acid, yet less danger of severe flushing or by-effects.

Indications — Vascular spasm, Raynaud's disease, intermittent claudication, varicose ulcers, acyocyanosis, chilblains, migraine associated with vascular spasm and Ménière's syndrome.

Administration — Treatment should be started with 1 tablet 3 times a day. If necessary the dosage may be increased to 4 or more tablets daily.

Safe, quick, easy . . .

TUBEX
PENICILLIN

WITHIN ONE MINUTE YOU CAN SET UP AND INJECT AN **ACCURATE DOSE** OF PENICILLIN

TUBEX LENTOPEN
300,000 I.U. Procaine Penicillin-G in Oil with Aluminum Monostearate

TUBEX LENTOPEN ALL-PURPOSE
400,000 I.U. Procaine Penicillin-G and Potassium Penicillin-G in Oil with Aluminum Monostearate

TUBEX WYCILLIN 300 SUSPENSION
300,000 I.U. Procaine Penicillin-G for Aqueous Injection

TUBEX WYCILLIN 600 SUSPENSION
600,000 I.U. Procaine Penicillin-G for Aqueous Injection

Also—WYCILLIN FORTIFIED and WYCILLIN for Aqueous Injection, single, five and ten dose vials.

Wyeth
Registered Trade Mark

NEW non-caloric sweetener stays sweet ... even in cooking, baking, canning

NOTE THE NAME **Sucaryl** SODIUM
TRADE MARK
(CYCLAMATE SODIUM, ABBOTT)

● *Non-caloric sweetener for restricted and low-calorie diets*

With SUCARYL Sodium, Abbott's new non-caloric sweetening tablets, patients on restricted or low-calorie diets will have immeasurably greater freedom in menu-planning — for now even those foods prepared by ***cooking, baking*** or ***canning*** can be sweetened without adding forbidden calories or carbohydrates.

And whether used in cooking, or simply added to hot or iced drinks, SUCARYL has ***no bitter after-taste*** when used in reasonable amounts.

Reports of clinical trials convey the enthusiasm with which patients have accepted SUCARYL. They not only welcome its wide range of uses as contrasted with saccharin, which loses its sweetness in cooking processes, but are virtually unanimous in their preference for the taste of SUCARYL.

Thus, for many housewives, the problem of preparing a special diet for one person will no longer be troublesome because dishes sweetened with SUCARYL will taste good to the entire family.

Each eighth-gram tablet of SUCARYL is equivalent in sweetening power to one teaspoonful of sugar. Tablets are effervescent to shorten dissolving time, grooved for easy separation to suit individual tastes.

SUCARYL Sodium is supplied in handy bottles of 100 tablets, available at pharmacies only.

Abbott

SEND COUPON FOR DIETITIAN'S SAMPLE

Abbott Laboratories Ltd.
Montreal

Please send me a dietitian's sample of 100 tablets of your new non-caloric sweetener, SUCARYL Sodium.

Name

Address

City and Prov.

The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX *NUMBER EIGHT*

MONTREAL, AUGUST, 1950

C.N.A. at U.B.C.

Average reading time — 14 min. 24 sec.

ONCE AGAIN the biennial convention—it was the twenty-fifth this time—has come and gone. Registration was high, yet so extensive is the campus of the University of British Columbia that there never appeared to be crowds, excepting when the participants, who numbered nearly a thousand, lined up for lunch in the cafeteria. Nature was exceedingly kind. Warm sunshine poured down most of the time. Those who had come prepared for the worst in weather found themselves uncomfortably warm in suits.

The greater number of the members who flocked in from all parts of Canada lived right on the campus. Union College housed the Executive Committee, while the rest of the members were quartered in Acadia, Youth Training and Fort Camps. Living accommodation was not exactly deluxe in quality but none complained. How could they with the incomparable view of mountains and sea from every window and door? One nurse was heard to exclaim that the views were so beautiful they did not seem real. The mountains at sunset looked to her like some vast, painted back-drop!

Very real regret was expressed by one and all that British Columbia's gracious president, Sister Columkille, was unable to be present, owing to illness. Her place was ably filled by first vice-president, Esther Paulson.

Holt

MISS HELEN RANDAL, *who was executive secretary of the R.N.A.B.C. when the last convention was held in Vancouver in 1936, views photos with* MISS ALICE WRIGHT, *present officer.*

Every possible detail for the comfort, convenience, and entertainment of the visitors had been perfected by the capable chairman of the Arrangements Committee, Mrs. Alison Wyness, and her well-coordinated batteries of assistants. At every session squads of student nurses, in their rustling uniforms, acted as ushers and were tireless in their enthusiasm to help. It was rumored that competition was so keen among these youngsters for the privilege of attending the sessions that new groups were given the opportunity each day. Truly, the convention was a great event in the lives of many people.

The deliberations of the Executive Committee were conducted during the three days prior to the week of convention. To celebrate on the Saturday evening, the members of the Executive were the guests of the Council of the Registered Nurses' Association of British Columbia at a unique party held at Steelhead Lodge, some 20 miles from Vancouver on beautiful Coquitlam River. Enormous steaks were barbecued over glowing coals by the genial host, Carl Jacobs, and served right out of doors. The aroma was tantalizing as the food was prepared. Since two sittings were required to accommodate all the guests, the less fortunate "second sitters" went for walks through the tranquil woods. Such steaks! Such gallons of coffee! It was, indeed, a royal feast!

Sunday

In the afternoon, Elinor Palliser, director of nursing at the Vancouver General Hospital, entertained at tea and afforded the visitors an opportunity of inspecting the commodious new nurses' residence that is nearing completion. One feature that aroused considerable envy was the sun-deck on the roof—nine storeys up.

A special service for the nurses, which was held at Christ Church Cathedral that evening, was very well attended. To mark the occasion, the scripture lessons were read by Miss Martin from St. Paul's Hospital and Miss Palliser. An unusual feature of the service was the unveiling and dedication of a beautiful stained-glass window given in honor of "the nurses of Vancouver who serve in war and peace."

Monday

Verbal greetings of welcome were brought to the opening session by Dr. G. F. Amyot, Deputy Minister of Health and Welfare for B.C., Mayor C. E. Thompson, and Dr. N. A. M. MacKenzie, president of the University of B.C. We were very honored to have Mrs. Elizabeth K. Porter, newly elected president of the American Nurses' Association, with us all week. Elizabeth Summers represented the nurses of Newfoundland in this their first convention with their fellow Canadians. Another welcomed visitor was Virginia Alcott of the faculty of the School of Nursing of the University of Washington, Seattle. Miss Alcott gave invaluable assistance with the work conference that discussed the evaluation and accreditation of schools of nursing. An added feature of the first day was the reading by the president, Ethel Cryderman, of the citations presented on the occasion of the awarding of honorary degrees by the University of British Columbia this year to two well-beloved and justly famous Canadian nurses. In order that these may be shared with all the nurses of Canada, the citations are recorded here in full:

> Mr. Chancellor, I have the honor to present for the degree of Doctor of Science, *honoris causa*, **Marion Lindeburgh,** Director of the Graduate School of Nursing at McGill University, who has brought selfless devotion, infinite persistence and rare distinction of mind and character to her lifetime task of advancing the art and science of nursing. As the academic governing body of the first University in the British Commonwealth to institute a degree course in nursing, the Senate of this University, in presenting her for this degree, pays tribute to her unconquerable spirit, her pre-eminence in this field, and gladly acknowledges the debt which contemporary nursing education owes to her.

Scene in the Auditorium at U.B.C. — June 26, 1950.

Sunday's Photos, Vancouver

Mr. Chancellor, I have the honor to present for the degree of Doctor of Law, *honoris causa*, **Laura Holland,** whose compassion for the unprotected, made effective by abundant common sense and great executive ability, has been responsible in large measure for our provincial child welfare programme and has contributed greatly by thought and action to the increasing efficiency of our national welfare services. In presenting Miss Holland for this degree the Senate pays tribute to one who has not only exemplified the highest devotion to human welfare herself but who has also the rare faculty of inspiring a like devotion in others.

The presidential address focussed attention on the problems of nurse shortage that still are pressing us on all sides. Miss Cryderman predicted that—

> As the implementation of the National Health program progresses, the current acute shortage will worsen. . . . It is abundantly clear that, with the current and the potential nurse shortage, immediate and positive action is required to conserve nurse power, to increase the number of nursing personnel, and to ensure the permanence of essential nursing service to the people of Canada.

Miss Cryderman's address will be printed next month.

A most enjoyable reception was held at Stanley Park Pavilion in the evening when the visitors were the guests of the alumnae associations of the hospitals in Vancouver and New Westminster. In the sunset afterglow the guests strolled through the richly-scented rose garden, visited the various memorial groupings, or were awed by the enormous trees that abound in the Park. And, thank goodness, there were no mosquitoes!

TUESDAY

This morning's session featured a panel discussion on the aims and accomplishments of the Metropolitan School of Nursing. Following the very lucid explanations by the director of the school, Nettie Fidler and her assistant, Eleanor Martin, it was recommended from the floor that each provincial association endeavor to arrange a similar program at district or other meetings to acquaint as many nurses as possible with the developments that have taken place. It was even regretted that a recording had not been made of the whole panel for future distribution and information. Much food for thought was contained in the vital report of the Educational Policy Committee.

Work conferences and general interest sessions commenced at two o'clock. There was considerable regret expressed that the members had had to choose "either/or" since so much valuable material was presented in both sessions. Particular mention should be made of the splendid neurosurgical demonstration put on by Alice Major of the Montreal Neurological Hospital. It is hoped that these procedures can be recorded on a film

Holt

Discussing the Metropolitan School of Nursing—left to right: A. MACLEOD, SR. ST. ALBERT, M. LINDEBURGH, N. FIDLER, M. KERR, A. WRIGHT, H. LAMONT, T. HUNTER.

so that the technique may be shared by a much larger body of nurses.

A special treat at the evening assembly was the concert put on by the nurses' glee clubs from the local hospitals. They were followed by a most provocative address delivered by Dr. Martin Cherkasky. In discussing the topic, "A Program for the Care of Persons with Chronic Illness," Dr. Cherkasky declared that there is a danger that we may be becoming too scientific and less human in our nursing care. "Humanity and kindness are such necessary ingredients," he said, pointing out the value of "T.L.C." in the emotional as well as the physical well-being of those suffering from long-term illnesses. "Many patients cannot be economically rehabilitated. Every one, however, should be given some incentive to improve his own lot. It is dreadful for any patient to feel he is abandoned to his fate."

An informal coffee hour, sponsored by the Greater Vancouver District and the Vancouver Chapter, concluded the day's activities. It was still early enough in convention week that many members had not had an opportunity previously to greet their friends from distant points. For some it was the first reunion in many years. So squeals of joy were heard on all sides as familiar faces appeared.

Wednesday

A report that will undoubtedly have far-reaching repercussions in our professional associations opening the morning session. Fully endorsed by all the provincial associations, it was proposed that a special committee and a director be appointed to make what is being called, for convenience sake, a *Structure Study*. The actual terms of reference have yet to be worked out in detail but essentially the plan includes a careful analysis of present and proposed activities in the C.N.A.; the relationships of the C.N.A. to the provincial associations which, by federating, compose the C.N.A.; what are national responsibilities, what are truly provincial, etc. It is hoped that this committee will be ready to present a completed report at the next biennial.

Holt

Joy be! The R.N.A. will help us get better working conditions.

Following the report of the Labor Relations Committee in which was incorporated the first statement of personnel policies to be officially adopted by the C.N.A., a "documentary" play was presented by the Victoria Chapter. Entitled "Yours for the Asking," this skit dramatized the feeling of frustration experienced by many general staff nurses over the inadequacy of working conditions and salaries, and their jubilation when steps, initiated by their R.N.A., resulted in steady improvement and progress. The prologue stated:

> In the world of nursing, we are just now beginning to feel our power and it is going to need wise guidance if it is not to be used solely for our own ends. In B.C., that guidance is available through the Select Committee of the Registered

Holt

Squadron Leader Frances Oakes *"ambushed" by Dominic Charlie, his wife and son.*

In the Banquet Hall (Head Table in the distance) — June 28, 1950.

Sunday's Photos, Vancouver

Nurses' Association. Indeed, it was for this very purpose that this committee was formed in 1946. Its members have studied labor legislation in all its phases in order to provide far-sighted leadership in the many problems facing nurses today.

The 1,300 nurses who attended the banquet held this evening will have a vivid recollection of the head table party being led down the aisle to the beat of Indian tom-toms. The banquet committee had an enormous task on their hands in preparing the interesting souvenir menus. On thinnest plywood the symbolic design reflected some of the historical developments of the hostess province. Joyce Rea, the nurse who had executed the bookplate design for the War Memorial Committee, was the artist.

A vigorous effort is being made to preserve the ancient Indian ceremonial dances. Several of these were demonstrated to the interested audience before the serious business of the Mary Agnes Snively Memorial lecture commenced. The accompanying photograph caught much of the atmosphere that was created.

Dr. Charlotte Whitton had aroused considerable curiosity by the choice of her title "Trumpet in the Dust." Her scholarly, inspirational address will be printed in full next month. Later, reprints will be available on request from our National Office.

Holt

The Banquet Committee: B. McCann, J. Jamieson, A. Wyness.

Thursday

Each of the special interest committees had extensive reports to consider during their sessions held

Holt

Steve Charlie beats the tom-tom while Isaac Jacobs, Dominic Charlie, and Mrs. Jacobs dance.

this morning. The Public Health Committee studied the report of the Bailey-Creelman Survey which has just been published. Institutional Nursing reviewed an extensive study of the present thinking and practice regarding the ratio of nursing assistants to graduate personnel in the hospital field. Private Nursing (and it will be noted that, with the adoption of an amendment to the C.N.A. By-Laws, the word "Duty" is henceforth eliminated) gave careful consideration to a proposed constitution and by-laws for community registry organizations.

At the noon hour, the R.N.A.B.C. Council was again the hostess this time to the National and Provincial Secretaries. The president and editor were also invited. During the luncheon, discussion developed on the international crisis and the best method of alerting the C.N.A. in the event of Canada becoming seriously involved. A small group was authorized to summarize our thinking and to prepare a resolution. This was presented to the general assembly at its final session.

Through the courtesy of the commanding officer of *H.M.C.S. Ontario*, tours were arranged over this ship during the evening. A very large number took advantage of the opportunity for a salt water cruise up Howe Sound on another vessel. The evening was so beautiful that most of the participants felt an urge to return again to the Pacific Coast for a longer voyage.

Holt

Nurses inspect the 42-foot scale model of H.M.C.S. Ontario. Shown here are: LIEUT. SALLY TROTTER; LIEUT. W. H. DAVIDSON, R.C.N. (R), EXECUTIVE OFFICER, *H.M.C.S. Discovery;* MRS. W. J. MACKENZIE.

FRIDAY

A re-arrangement of the program placed the address by Florence H. M. Emory in the morning session. A widely-versed authority on the activities of the I.C.N., Miss Emory spoke with emphasis and conviction on the role of "The International Council of Nurses—A World Force in Nursing." This paper will also be found in our September issue.

The summaries of the ten work conferences were presented after lunch. The most significant factor emerging from these reports was the feeling that the time was too short to permit the adequate exploration of the avenues of study that were opened up. Various suggestions were voiced as to how this difficulty could be overcome, such as a period of two or three days immediately preceding or following the convention. There was no question but that such work conferences were a popular addition to the regular program. Some advocated that, since the C.N.A. has demonstrated the effectiveness of this form of program, it should now be developed in conjunction with provincial rather than national conventions. This whole matter will be considered by the new executive.

FINALE

No report of the convention would be complete without some comment on the splendid representation from the student body in our schools of nursing. With over 80 registered, every province excepting New Brunswick and Nova Scotia was represented. Indeed, Prince Edward Island had six students there. For the first time, one of our French schools of nursing, Notre Dame of Montreal, sent two students. Their special program was launched with a dinner on the first evening, sponsored by the Student Nurses' Association of B.C. Serious discussion of their problems highlighted their own work conference. They were prepared to tackle almost any topic presented with candor and

Holt

At the Student Nurses' Dinner Party.

a surprising degree of maturity. They heartily endorsed the development of student nurses' associations under the egis of each provincial registered nurses' association.

The final episode of the convention came around four o'clock when, the new slate of officers, chairmen, and sisters having been announced, Miss Cryderman called the president-elect, Helen McArthur, to the platform. It was a solemn moment as the president's charge was given. Later, flanked by her vice-presidents, the new president received the gavel—the symbol of office—from the retiring president, who said, "In the name of the Association, I leave the affairs of all of us in your capable hands."

To Miss F. Verret was accorded the privilege of extending an invitation, on behalf of the Association of Nurses of the Province of Quebec, for the 1952 general meeting to assemble at the Chateau Frontenac in historic Quebec City. Let's all be there!

Copies of any of Lee Holt's pictures (9" x 7") may be secured for 75 cents each by writing him at ***1915 Haro St., Vancouver.***

Alberta

The following news has been received concerning staff members of the Alberta Division of Public Health Nursing:

Laura Graham, Dean of Women, School of Agriculture, Vermilion, and *Margaret M. McKim* from the School of Agriculture, Olds, are serving for the summer months in the districts of Tangent and Worsley, respectively. *Mina T. Pool* has been appointed to the Athabasca health unit at Colinton. *Marion Story* is with the Child Welfare Clinic, Medicine Hat. *Jeannette McInnis*, New Brigden, has resigned to be married. *Olive F. Watherston*, Tangent, has resigned and left on an extended trip to England. *Amy L. Conroy*, Lindale, and *M. E. Hagerman*, Medicine Hat, have both retired from the staff after many years of service. *Helene B. Janson* of Plamondon has resigned. *Jean S. Clark* is sailing for Scotland on an extended leave to take post-graduate work in Glasgow.

Good Light Needed

According to Luckiesh and Moss, who have done much research on lighting needs, workers in various occupations require foot-candles of illumination as follows:

100 foot candles or more—fine needlework, fine engraving, fine assembly, and sewing on dark goods.

50 to 100 foot candles—proof-reading, drafting, watch-repairing, fine machine work, average sewing and needlework.

20 to 50 foot candles—clerical work, ordinary reading, bench work, average needlework on light goods.

10 to 20 foot candles—ordinary office, factory, reading, sewing work.

A light meter, which is an electric cell actuated by a light beam which causes a needle to move along a calibrated dial, can be used to measure the number of foot candles in any situation.

—Dr. Leonard W. Jones

Helen McArthur, President

THE APPLAUSE of many hundreds of nurses, on June 30, 1950, welcomed newly-elected **Helen Griffith Wylie McArthur** to the presidency of the Canadian Nurses' Association.

Our new president is widely known all across Canada and to nurses in many parts of the world. Born in the southern Alberta community of Stettler, Helen McArthur represents the fourth generation of her family to be born in Canada since the original ancestors migrated from Scotland. Gay, light-hearted, always ready for some fun, young Helen romped through her years at public and high school, winning high marks in casual style.

When it came time to think of going to university, Helen McArthur decided an ordinary arts course did not interest her. She enrolled in the School of Nursing at the University of Alberta, completing in 1933 her undergraduate training at the University Hospital, Edmonton. Those were the lean years in university financing. Since no final year nursing courses were currently available at the U. of A., she journeyed to the University of British Columbia where she majored in public health nursing, receiving her B.Sc. degree from Alberta in 1934. Six years later she was awarded a Rockefeller Fellowship for post-graduate study and secured her M.A. from Teachers College, Columbia University, New York, specializing in supervision and teaching.

HELEN MCARTHUR

Miss McArthur's first appointment in 1934 was as senior public health nurse with the Foothills Health District, High River, Alta. Here with five small urban communities and the surrounding rural area as territory she assisted with the intensive, generalized program that was being developed. Her appreciation of the value of good public relations is rooted in the experience she secured there in interpreting a public health nursing program to the community.

In 1937, Miss McArthur's restless spirit urged her to launch out into a new area in northern Alberta to carry on a rural generalized program which included all aspects of maternity care as well as the usual morbidity services. Far removed from the nearest doctor, she had many weird and wonderful experiences during the two years she was stationed at Kinuso. All-night rides in the caboose of freight trains, struggles with a cook-stove that would smoke prodigiously but seldom get really hot—this pioneering effort hardened Miss McArthur's determination to improve the lot of the nurses working in remote settlements.

Following her return from study in New York, Miss McArthur was appointed to the faculty of the University of Alberta. For four years she was acting director of the School of Nursing. In 1944, she was given her opportunity to expand the provincial nursing service when she was named director of the Public Health Nursing Division of the Alberta Department of Public Health. Two years later, Miss McArthur moved into a wider sphere of activity when she was appointed to her present position as national director of nursing services with the Canadian Red Cross Society, with her headquarters in Toronto. The recent flood and fire disasters have meant busy days and nights.

A firm believer in the inherent responsibility of nurses to participate in the activities of their professional bodies, Miss McArthur has filled many offices with enthusiasm, energy, and accomplishment. She worked up through various levels to become first vice-president of the Alberta Association of Registered Nurses in 1946. In 1944 she became chairman of the Public Health Section of the C.N.A. and simultaneously was elected chairman of the Public Health Nursing Section of the Canadian Public Health Association. It is characteristic of our new president that she filled her role in both of these offices with a level-headed leadership that resulted in considerable progress. In 1948 she was appointed convener of the C.N.A. Public Relations Committee. She has been one of the representatives of the Red Cross on the Demonstration School Administration Committee since its inception.

Being a well-balanced individual, Miss McArthur finds time in her busy life to play and enjoy herself. An avid reader, fond of music, she broadens her mental perspective through many community contacts, including membership in the Zonta Club of Toronto.

This is our new president! Well versed in nursing affairs all over Canada, acutely aware of the need for progressive leadership in nursing, a fluent speaker, a dynamic personality, Miss McArthur warrants our whole-hearted, loyal, and enthusiastic support as she begins her new tasks as president of the Canadian Nurses' Association. She will not fail us. We, the nurses of Canada, must not fail her.

Nursing on Canada's Rooftop

IVY MAISON

Average reading time — 9 min. 36 sec.

SCATTERED across northern Canada, from Coppermine and Fort McPherson within the Arctic Circle to Eskasoni in Nova Scotia, are hospitals, nursing stations or health centres, and dispensaries, established by the Department of National Health and Welfare's Indian Health Services to give aid to the Indian and Eskimo population who live or wander far from the more thickly populated areas. Although the Indians and Eskimos are very dissimilar, they are, for legal purposes, grouped under the one name of Indians.

The Indian hospitals are operated in much the same way as any community hospital but the nursing stations are another matter, with an interest all their own. They are small buildings with accommodation for not more than four short-term or emergency cases and with living quarters for the nurse-in-charge (a graduate) and her assistant—a highly experienced practical nurse who combines that role with housekeeping. In addition to the two nurses, a local woman is employed to do the heavier housework and a man to look after fires and water supplies. The latter two people usually live out.

The station is the particular responsibility of the nurse and the surrounding district is her little kingdom. The department's doctors pay periodic or emergency visits but it is the everyday duty of the nurse to look after the health of the natives, young and old. To the native she is a *Very Important Person*. He relies upon her in the event of sickness or accident to himself or his family.

Prenatal and well-baby clinics are pet projects of the nurse. They are organized and held regularly. She also operates out-patient clinics to which come an assortment of cases ranging from pediculosis to ingrown toe-nails, from infected eyes to cut fingers.

Most of the nurses are in favor of visiting the patients in their homes. By this means, cases of sickness are often found which would otherwise go unreported. Also it is often possible for her to do something about improving unhealthful conditions in the homes.

The schools are another fruitful field for the nurse. With the wholehearted cooperation of the teachers, during the examination of the children she can keep a watchful eye on these small individuals to see that they get immunization against the preventable diseases, prompt medical attention when they need it, and some supervision over their nutrition. The family allowance provides money towards the Indian child's welfare just as it does for the white youngster. In northern areas the cheque is placed to the credit of the family with the local trader, who is usually of one mind with the nurse as to what constitutes nourishing food for juveniles. Papa couldn't chisel a can of tobacco on the children's food account, even if he so desired.

In her area, the nurse is usually one of a group of white people numbering anywhere from 20 to 100. Most of them are engaged upon some project which will have a beneficial impact upon mankind in general. Doctors, scientists, meteorologists, radio men, armed forces and R.C.M.P. personnel, traders, Indian superintendents, and independent white trappers, stationed in these isolated parts of Canada, depend upon each other for social activities. Life may sound lonesome but the Northland has a way of getting into the blood of those who have spent any length of time there and it stays with them forever. The first three months of a nurse's sojourn are the deciding ones—it is the North against the attractions of the friends and good times she left behind. After the first year, nothing but matrimony is likely to remove her. It has happened occasionally that, unless she has married someone she met up there, she will talk about her experiences so persuasively that she converts her husband and takes him back with her.

NFB Photo

Solace and care for a youthful patient.

The Indian is an interesting and contradictory character. He is, by turns, likable and exasperating, kindly and mean, sometimes cooperative and often just plain cussed, always childlike in his emotions and understanding and usually indolent. He loves attention and bandages—lots of both! One day a stalwart presented himself at a nursing station, his hand and arm heavily swathed in bandages and the arm supported in a sling. When layer after layer of cloth had been removed, the nurse found that he had a fish-hook embedded in his middle finger. She gave him a local anesthetic and, with a scalpel, made a clean cut in the finger and removed the hook. She dressed the finger and the brave went happily on his way minus, however, a few yards of wrapping.

Pneumonia is of fairly high incidence among the natives and various forms of influenza quickly develop into pneumonia, so the nurses are particularly alert to any outbreaks of the disease. One Indian woman had been visited on one occasion. She was found to have a cold, with no apparent complications. The next day, another woman came to the station and, in her broken English, announced that her friend was "Awful sick! Maybe die!" Then she put on a really expert imitation of gasping, of drawing a long, shuddering breath and groaning. The nurse lost no time in calling an Indian with a canoe to take her across the choppy half-frozen lake. Huddled at the bottom of the canoe under a tarpaulin, she felt the icy water splashing over her and she could see that the Indian was having difficulty in making a turn. When they reached the opposite shore, nurse, tarp and canoe were frozen together. However, she got herself organized and made her way up the hillside to the cabin at the top. Inside she found a stove burning warmly—and her patient sewing, breathing quite calmly and evenly! As the nurse thawed herself out at the fire, she did some thinking,

National Health & Welfare Photo

Dressed up for Clinic Day.

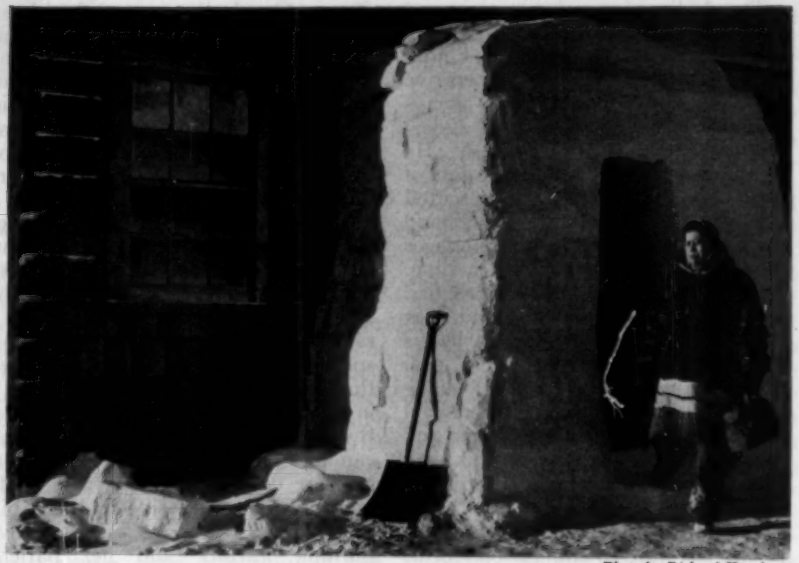


Photo by Richard Harrington

Winter attire. Note the "snow door-way."

instead of hitting the roof as most people would have done. She thought of this woman alone up here with her three children, her husband far away on the trapline. She was just *lonely!*

Along with a few pills for the cold went friendly words in the native tongue and a kindly touch of the nurse's hand. Then the nurse petted the little children before she set out once again on her trip across that dark angry lake. She knew that her visit and her friendly talk had done more for that lonely Indian than any medicine could do. She even managed a grin as she thought of the histrionics of the woman who had come to call her. In addition to her standard equipment of skill, courage, patience, and understanding, the nurse needs a good workable sense of humor that can, on occasion, be used against herself.

If the natives like the nurse, she can wield a very strong influence over them. Not only will they bring the family to the clinics for examination and immunization, take medicine she deals out for them, but they will even go to the length of *washing themselves*, sometimes approximately daily. The Northern Indian regards water as an excellent medium for floating his canoe or for holding fish for him to catch, but he sees no useful purpose in removing the natural accumulation of grime from his own hide. After all, it just collects there again. However, if the nurse wishes it, he'll go along with the gag. These white people are funny!

In spite of the native's antipathy to soap and water, he has developed a great confidence in the immunization plans of the government to protect his children from preventable diseases. Time was when an epidemic could strike an Indian or Eskimo settlement and wipe it out in short order. Now, under modern methods of protection, the native can see for himself the value of the white man's precautions and of the medicines which are sent to him by Indian Health Services. So much in favor is the nursing station that in one district, where one was badly needed, the Indians themselves put up the building, leaving the government to supply only the windows and doors. These people are quite likely to regard their nurse as a minor deity, if they

like her. She will be dealing with conditions that are primitive, where there are no luxuries but where, since no one else has them, they are not missed. Everything in the station is the best of its kind in the way of equipment and furnishings to give the nurses all possible help in doing their work efficiently, but there is no corner drugstore to run to for cosmetics and frills.

She will have that joy of all rural areas—the mail order catalogue. Even the native has taken to this in a big way! Even though he is unable to read the description, he sees the picture and decides that the article advertised will fill a great need in his life, so he puts in his order. Sometimes, the local trader acts as agent for the big mail order houses, despite the fact that they are making inroads into his own business.

Transportation for the nurse runs the gamut of vehicles. One nurse travels her territory on horseback, since there are no roads fit for wheeled traffic; another, on the Alaska Highway, uses a truck of ancient vintage. Canoes, gasoline launches, automobiles, wagons, dog-sleds, even—in case of emergency—the plane, are used for getting to and from her places of call. Although many of the girls enjoy travelling by dog-team, the Department does not encourage this mode of travel except on short emergency trips.

Dress for the northern nurse is different. She usually keeps her hospital uniforms for special occasions, such as visits from officials and doctors and for immunization parades and clinic days. The native regards the clinic as a very special occasion, so the nurse does the occasion honor, too, by wearing her regular hospital uniform. For her visits outside during the summer she usually wears a suit. In the far north, she wears fur garments for which the Department pays. She selects the pelts at the local trader's, then takes these "dress goods" to the best of the local seamstresses to be made up into slacks, parka, gloves, and mukluks. The outfit is always very becoming and, so garbed, the nurse can face anything the weather has to offer.

For the health centre nurse in the north, a course in public health nursing is an asset, providing she has not specialized too highly, especially in administration. She will need a deep love of her own work and a liking for and understanding of a simple childlike people, whom she can help to better health and living conditions.

Canada's medical aid to the Indian grew out of an "understanding" among the early white settlers that the doctors attached to units of the armed forces would give their services to the native peoples as required. In 1922, an attempt to organize this system was made and several field nurses were appointed. By 1927 the organization had grown somewhat and a very few more had been added to the staff. Today there are 55 field nurses, exclusive of those attached to the Indian hospitals.

A system of radiophones is gradually bringing the nursing stations into direct contact with the nearest doctor in the area or, where the station is not individually equipped, the nurses use the local radio, sometimes that of the local game-warden, the Hudson's Bay Company, or any government project so equipped. By this means, in emergency, the nurses can always summon a doctor or discuss with him any problem that arises.

As the Department adds more and more hospitals, nursing stations and dispensaries, more field nurses will be required. To the girl who likes adventure-with-the-job, there will be plenty of opportunities for those qualified to join the Indian Health Services.

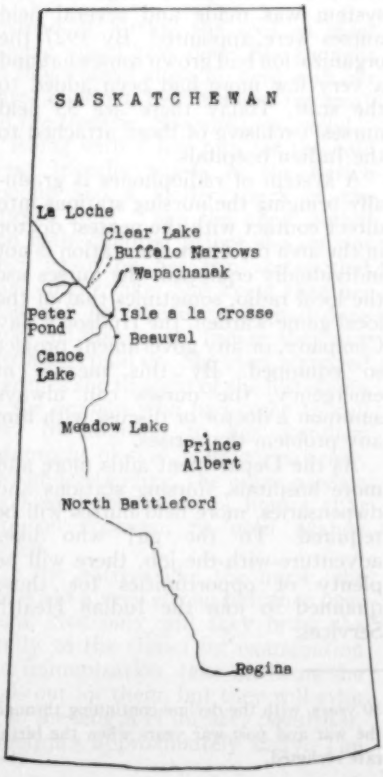
The rate at which births of seventh or higher number of children per family occur has dropped by nearly 60 per cent in the past 30 years, with the decline continuing through the war and post-war years when the birth-rate rocketed.

A Health Survey in the Far North

MARY E. MCCANN, B.SC. N.

Average reading time — 17 min. 24 sec.

THE PUBLIC HEALTH nurses were responsible for the new step in the diagnosis and treatment of disease among the Indian, Metis, and white population resident in the remote northern areas of Saskatchewan. The health of the Treaty Indians living on the reserves is the responsibility of the Federal Department of Indian Affairs, but the remaining population is the responsibility of the Saskatchewan Department of Public Health. One medical officer stationed in Ile à la Crosse has, for the past three years, devoted his service to this remote and scattered population. He has had the assistance of a public health nurse stationed in a small hospital at Buffalo Narrows. The nurses in their infrequent visits "out" had reported that syphilis and tuberculosis appeared to be rife among their people. It was at their suggestion that this survey was made.



The joint resources of personnel and equipment of the two departments were pooled and arrangements were made to carry portable x-ray equipment, a portable laboratory for syphilis serology, and a generator to supply the necessary power. In order to test the feasibility of the scheme and to smooth out possible technical difficulties a preliminary survey was made the previous summer when three less remote areas were visited by car. It proved to be workable and, as a result, the survey which we are about to describe was made. The area visited lies in the extreme northwest of the province and it is possible that soon the northeast portion of the province will be surveyed.

The only feasible opportunity for conducting such a survey is at the time of Treaty payments when the Indians and Metis gather and when the travelling facilities of the Department of Indian Affairs are available. It was, therefore, planned that a medical team would accompany the Treaty party in order to take chest x-rays, do smallpox vaccinations on everyone, and to take blood samples for syphilis serology (the Kahn test) on all over the age of 15.

The medical party, consisting of the doctor in charge of Indian Affairs for the province, his secretary for the necessary clerical work, an x-ray technician, two public health nurses, and two laboratory technicians, met

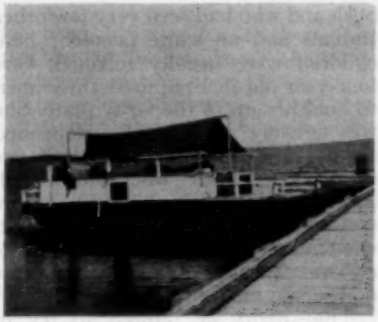
Miss McCann is a staff nurse with the Saskatchewan Department of Public Health

the Treaty party, consisting of the Indian agent and an assistant, at Meadow Lake. A member of the R.C.M.P. also joined us and remained through the entire trip in order to carry, and guard the thousands of dollars of Treaty money. Laboratory equipment had been transported by car as far as Meadow Lake and x-ray equipment by panel truck. There it was all loaded on a freight truck and we were off on the first lap of an arduous but interesting and thoroughly enjoyable adventure. There was a spirit of co-operation everywhere. Throughout the trip it was a source of amazement that a group of people could be so happy under adverse conditions. The work was hard, the hours long, living conditions were extremely primitive, and yet you could not imagine a happier crowd.

The truck ride was almost beyond description. Our first stop was to be at Beauval some 110 miles north of Meadow Lake. The first 30-odd miles to Green Lake were only bumpy but from there on the trail dwindled to nothing. The frequent bumps and boulders almost shook us to pieces and left us breathless. Someone started a sing-song and soon everyone had joined in accompanied by a mouth-organ. Half way we stopped for tea. The men built a fire and we used the laboratory test-tube pail as a teapot.

We arrived in Beauval to find the barge, which was to be our home, anchored in the river. It was the only one of its kind on the lakes, operated by the owner and his 15-year-old son. The top of the barge, measuring about 20′ by 10′, flaunted a green canvas canopy open at ends and sides. At one end, stairs led to the galley which boasted a long wooden table, wide benches folding back to the wall, an old wood-stove, innumerable shelves, and cartons of food supplies. The barge was pulled by a tiny tug which we soon nicknamed the "Little Toot."

Everyone of our party will always remember the first night on the barge. Apparently only two girls were expected and they were to have had the two bunks on the tug. When five of us and a cook arrived, we had to sleep



The famous barge

in the galley while the men slept up on deck. The mosquitoes were impossible! No amount of repellent seemed effective. Every 15 minutes or so, someone was out of bed making another round with the flit gun. Apparently the men up on deck were having the same difficulty. Finally, they came down to make coffee which we shared gladly. Soon we all decided that sleep that night was out of the question. Shortly after three we rolled up our sleeping-bags and dressed.

We set up our equipment in the old schoolhouse at Beauval. Our supplies were transported by a horse and buggy owned by the local priest. In the entire territory we covered, we received the greatest cooperation from the priests. They had explained previously to the people that everyone —Treaty or non-Treaty—were all welcome and they certainly did turn out. We did not finish until after ten that night, having completed 251 vaccinations, 136 bloods, and about 260 x-rays. The people were most friendly but very few spoke English so we had an interpreter with us at all times.

The chief called the people in by families and cards were filled out for them. The women and girls were shown to a dressing-room where they stripped to the waist and put on gowns in which to be x-rayed. The men merely removed their shirts before stepping up to the machine. Most of them came to the clinic willingly but occasionally a family came who had lived almost completely alone in the

bush and who had seen very few other Indians and no white people. These children were usually terrified. One four-year-old girl required three men to hold her up to the x-ray plate. She was fighting as if her life depended on it—rigid with fear. We had one idea which worked wonderfully well. After a child had been vaccinated he was given a few candies. The parents were very pleased and often the children wanted to come back and be done again just to receive more candy.

That night we refused to try to sleep below again so carried our sleeping-bags up on the top deck with the others where, with a slight breeze, the mosquitoes were not quite so troublesome. About three in the morning we wakened suddenly to find ourselves slowly moving up the Beaver River. We sat up for a while marvelling at the beauty of the country. When we awoke again at almost eight, we were within sight of Ile à la Crosse.

Here again we set things up at the school—this time in a very modern building, the equal of any found down south. A stoneboat and tractor were our means of transporting the equipment to the school where we were soon very busy. By seven that night we had seen well over 200 persons. They have a small but very fine and well-equipped hospital at Ile à la Crosse which is run by the Sisters.

Ready for x-ray and immunization

They were most kind to us, showing us about and answering our many questions. For the most part the Indians appeared to be a cleaner and healthier group than those found on most of the southern reserves close to the white man. Heads were clean, there was little evidence of skin disease, and the clothing was all fairly new. We were told that when clothing wore into holes it was seldom patched but discarded and new garments purchased. The one lasting feature of the Indian's dress is his moccasins. Men, women, children, and small babies all came wearing beautifully beaded moccasins. In the majority of cases rubbers were worn over these to protect them.

It was decided that we should leave at about eight for Buffalo Narrows where we were to work the next day. The Indian agent and his assistant had planned to go by canoe and offered to take one of us along, expecting we would be there long before the barge arrived. I was the lucky one and after a short delay, including picking up 250 pounds of nails at the Hudson's Bay Company store, we started up Deep River. It was a grand trip but toward eleven o'clock the skies became very dark and there was lightning close by. Finally about midnight it began to pour. Although I had a ground sheet around me, I was drenched. The river too became very rough and we were forced to pull in to shore. In that uninhabited country we were more than lucky in finding an old deserted shack. The roof leaked in places but we laid our sleeping-bags on the floor amid the clutter of broken bottles, old rusty tin cans, filthy newspapers, straw and mice and soon were sound asleep. The sun shining through the window wakened us in the morning. After a wash in the river we went on to Buffalo Narrows. We found the barge (which had also been forced to anchor near the shore until the storm was over) had just arrived.

All Wednesday we worked at the small, bright school at Buffalo Narrows. Next door was a tiny but lovely hospital run by one of our public health nurses. She went out of her

way to assist us with our work and to extend to us that very much appreciated northern hospitality. During the day we had a little excitement. One of the boys accidentally dropped a lighted match in the waste basket where I was throwing ether sponges used in the vaccinations. The resulting blaze spread and by the time we had stamped out the flames I had burned the stitching on my shoes and was forced to wear my slippers until I had a pair of moccasins made. By night we were not finished but since our plane was coming in the morning to take us to La Loche, we promised to return and complete the work on Saturday.

Thursday morning we flew to La Loche on Methy Lake. This was our one plane trip, taking over an hour, but it was apparently the only way into the outpost. We again worked in the tiny school, met with wonderful hospitality, and the people turned out well. We were all very impressed by the way in which the Indians, most of whom had travelled long distances with large families, set up their tents and then very patiently awaited our arrival. There is no hurry or commotion such as one sees in the cities. Time means nothing to these people. Everywhere we stopped we noticed that no activity could be seen anywhere until 11:00 a.m. There seems to be no morning at all.

Several things impressed us about the Indians. The most outstanding thing was the rapidity with which they seemed to have aged—young people of 20 looked 30, people of 45 looked 60. One could understand when one saw a 15-year-old married girl come in with one or two children, and this is common. The hardships of living and the lack of all modern conveniences would probably be a great factor, too. One modern invention they nearly all appeared to have was a motor for their canoes; paddles appear to be becoming obsolete.

That night we girls slept in a bed —the only bed in three weeks. Some of the Sisters at the four-bed hospital were on holidays and accommodation had been arranged for us there. The men were not so fortunate—they slept on the schoolroom floor.

The following morning we completed our work and, while waiting for the plane to arrive for us, we walked about visiting Indian tents and attempting to carry on some kind of conversation with the people. We also watched the workmen constructing the new hospital, a welcome addition to the present small one. The Sisters are doing outstanding work, particularly in attempting to admit maternity patients for a 10-day period. During this time, with the excellent care they receive, the women are bound to gain some knowledge which they will take home with them and, as best they can, put into practice. The priest spent some time telling us of his people.

Saturday, as planned, we completed our work at Buffalo Narrows and were pleasantly surprised by an invitation from the public health nurse to a chicken dinner and, later in the evening, a weiner roast at McKay Island, a short distance by boat. We were always pleased when we could get away from the wharf at Buffalo Narrows as there is a large fish packing plant and the smell was most unpleasant. With the mouth-organ, our lusty voices, and lots of weiners we had a wonderful time on the island.

Sunday about noon we left for Peter Pond Lake. About two o'clock our skipper decided it was too rough to enter the large lake so we pulled into a cove and spent the afternoon. In the shelter it was warm, calm, and peaceful. We swam and, as there was a beautiful sandy beach, most of us tried to secure a tan. We went fishing and before long we all had a pile of fish beside us. They were mostly pickerel and just begging to be caught. After a supper of delicious fried fish, we left for Peter Pond. About nine that night we anchored a mile from the settlement called Dillon.

Early on Monday morning we walked along the wet sandy shore to the outpost. There was no school or hospital so it was decided that we would use the Chief's house. He is

We go fishing

Chief of the Chipewayan band, although a large number of the people we worked with were Cree. The languages are so different it is completely impossible for one to understand the other.

Tuesday was spent in travelling to Clear Lake where we arrived in the late afternoon. It was another beautiful day and a lovely trip. It is somewhat difficult to say whether the country is one great piece of land with a million lakes or thousands of islands in one large body of water. This was noticeable particularly from the air. At Clear Lake we found we were to work in the Chief's house but would not begin until the next morning. They were building a new church at Clear Lake. The priest told us that when the old one had burned a year ago, all that was saved was the big church bell. He rang it for us and it was still clear and perfectly toned.

The next morning we found things were going to be very crowded. The x-ray equipment was put in the small house and the doctors made their examinations there. Outside on the porch the nurses had their tables and equipment for vaccinating and taking bloods while on the other side the two technicians set up their laboratory. All day we had quite an audience of curious Indian children who appeared fascinated by the procedure. When the people had gone through the clinic, the Treaty Indians went down to the barge to receive the Treaty. Here I attended my only band meeting. Apparently, after all the Treaty has been given out, the Chief, councillors, and as many of the band as wish, meet with the Indian agent to discuss their wants and problems and to voice any complaints. One would be surprised how greatly these people's problems resemble our own.

Wapachanak was our next stop. It was necessary for us to portage about a mile from our anchorage, due to a series of rapids which could not be attempted by barge. The walk was lovely and served to create an appetite. Our first day working here was so hot that several Indians fainted and it was necessary to continue the following day. This delay caused us to run into bad weather. We were forced to remain anchored until Monday.

When we returned to Ile à la Crosse there was only one more trip left for us but it proved to be the most interesting. We were to go up Canoe River to Canoe Lake one day, spend the next day working, and return the following day. Canoe River is aptly named as it is so shallow and full of rocks that only an experienced guide with his canoe could find the way. The supplies were transferred from our barge into nine canoes, each with its guides hired for the trip. Two of us were alone in one of the smaller canoes which had just one Indian. Before we had gone very far we came to some rapids up which it was necessary to pole. Our Indian was having a great deal of difficulty making progress so finally he turned to us, handed each a paddle, and said, "Work." We worked, much to the amusement of the people in the other canoes. At the first opportunity a re-arrangement was made so we had at least two men in all the canoes.

It was a beautiful sight watching the canoes winding in and out among the rocks and rapids following almost exactly in the course of the first canoe whose guide knew the river well. On one occasion it was necessary for us to get out and portage while

the Indians took the canoes up a long stretch of especially treacherous rapids. The portage was through thick brush and we sank in muskeg up to our knees. Being so damp, the mosquitoes were out in full force and we had to carry branches to keep them away. After a short distance the muskeg dried and we were forced to put our shoes on and roll down our slacks to prevent the dry branches and twigs from scratching our legs. At the end of the portage we made a smudge and sat down to wait for the canoes.

After 12 hours' travelling we arrived at Canoe Lake and found refuge in the small house belonging to the priest who was away at that time. While some slept in the tent pitched by the Mountie, the rest of us spread sleeping-bags on the floor. Being accustomed to such a hard mattress by this time, we slept very well.

We were all beginning to feel that the trip was just about over by now. We returned to Ile à la Crosse and continued by barge to Beauval where we spent the afternoon at the Indian Residential School. As the Indians on the reserves become acquainted with the advantages of having their children attend the school, more and more are being sent yearly until now they have 150 boys and girls. Schooling is not compulsory for them. The school, with a priest as principal and a number of Sisters and Brothers to help him in his work, is completely self-supporting. It was built of bricks which were made on the grounds. They have their own power-house, carpentry shop, machine and welding shop, sawmill and lumber yard, and a farm complete with stock. For the girls there are sewing-machines and

Poling upstream

even looms where they weave the cloth with which they make clothing for themselves. Each yearly holiday time the children are sent home with a new set of clothing they have made personally. One would think it impossible for these Indian children, after receiving several years of such fine education, to return to the reserve and fall into the backward and often unhealthful habits of their people. Yet many do seemingly forget all they have learned.

The following morning our truck was waiting for us. We climbed in wearily, loaded our equipment for the last time, and somehow survived the long and even rougher ride back to Meadow Lake. The soft hotel beds felt good but most of us had to put our blankets off the bed onto the floor before we could sleep.

Altogether we completed over 2,300 x-rays, about 2,200 vaccinations, and some 1,220 bloods. The results have been most enlightening and it is felt that if such a survey can be continued from year to year, followed by necessary treatment, we will soon have both the tuberculosis and venereal disease rate under excellent control in far northern Saskatchewan.

The efficiency of a physical therapy department may be seriously impaired by having the available time and space for treatment monopolized by old cases which have passed a point where specific benefit may be expected but whose orders have not been changed by the attending physician. This causes unnecessary expense to the institution or patient, or both, and interferes with the effective treatment of other cases. It is as important to know just when to terminate or make a transition in physical therapy as it is to know just when to prescribe it. For example, after a fracture the prolonged use of heat without making a transition to contrast applications (cold, massage, etc.) leads to passive congestion, followed by chronic swelling and thickening.

Highlights of Treaty at Oxford House

JOAN EDWARDS

Average reading time — 5 min. 48 sec.

ABOUT the second week in June, the Indians started arriving from their winter camps to attend the treaty. Almost overnight a tiny village of tents sprang up. The ones owning homes started cleaning up their yards to a noticeable degree. New dresses were purchased by the women and girls, and gaudy shirts and windbreakers by the men and boys. A few went so far as to get their hair cut! All was in readiness.

At treaty this year the Indians were fairly well dressed. In fact, one of the medical party commented on how clean the Oxford House Indians were and how nice their clothes appeared to be. That was true but the sad part is, in the majority of cases, the new clothes are all that they have and will be worn, sometimes without change, until next treaty. A few days before treaty the family allowance cheques came in and with this money the new things were purchased. If it had not been for these cheques many would have been in rags.

At this time, too, they were fairly well fed as fish and ducks were plentiful and the Indian diet was augmented by the occasional moose. One Indian does not keep a moose for himself and family but shares it with all his friends and neighbors. Thus the majority had a taste at least.

The plan at each treaty is that the people must have their x-rays and inoculations first and then collect their treaty money. This has been the custom ever since the medical group accompanied the treaty party for the first time. The Indians understand this arrangement and make no fuss about being x-rayed and inoculated. This year a health talk was given by the doctor and one of the x-ray technicians in front of the chief and councillors. The talk was enthusiastically received and made a big impression. X-ray plates were shown to those in attendance and their meaning explained in simple terms.

On the first morning of the treaty, the medical party went by canoe from the nursing station and landed near the United Church, where the x-ray equipment had been set up in readiness the night before. Although there did not seem to be many people around when we first arrived, within a few minutes the door-way of the church was crowded. The first few families were x-rayed and inoculated with combined diphtheria and pertussis vaccine within a very short time. The doctor examined them as they passed. Any needing teeth extracted received attention. Some with boils were given penicillin in oil, etc.

The head of each family received a slip of paper upon which was written the number of members of his family. This he took with his treaty card to the Indian agent who had his headquarters in the Council House. There, with an R.C.M.P. standing by in his impressive uniform, each Indian received crisp new dollar bills in the amount specified by the size of his family. The satisfied grins at this point were many.

Back in the church the work went on, while little noses were pressed in fascinated interest against the window-panes. In the churchyard we could see whole families sitting around on the grass, waiting for some of the congestion to ease away from the door. Then they in turn entered and had their x-rays, etc. Even after the different families had received their treaty money, they came back and sat around watching the remainder go into the church.

By noon on Monday, July 4, all x-rays had been taken and inoculations

Mrs. Edwards is field nurse at Oxford House, Manitoba, under the Federal Indian Health Service.

Whole families sat and waited their turn.

given. There had been 433 persons (including seven whites) x-rayed, 276 inoculated.

In the afternoon, B.C.G. vaccine was given to 84 Oxford House children and three non-treaty children. This was something new to these Indians. They submitted quite willingly and, in general, seemed to understand that they would benefit by it. Of course, being very superstitious, they didn't speak of it as vaccine. The B.C.G. is, to the Oxford House Indian, "strong, white man's medicine" and they let it go at that. Several times I heard the remark passed "musko-a muskeekee" (strong medicine) in reference to the B.C.G.

After the treaty party left, a dance was held at one of the homes and nearly every young Indian on the reserve attended. They do the old-fashioned square dance chiefly. Oddly enough the dances are all "called" in English.

Next evening canoe races were held. During the afternoon "the plate was passed" and donations from ten cents to five dollars were received for prize money. The races were to start at eight o'clock and crowds gathered along the shore to watch. The first race required that three men be in each canoe—one at the stern and one at the bow with paddles, one in the centre with oars. The oarlocks are very unusual, being primitively fashioned from tree branches and nailed to the side of the gunwale. The oars themselves are nearly all home-made.

If it had been young white men in the race, practice runs would have been held for days or weeks in advance and the canoes would have been checked and rechecked hours before the races. Not so with the Indians. After much urging and coaxing two canoes with the necessary crews went to the starting line. Two were not enough for a good race so one of the white men went about coaxing others to enter. Finally, one of the canoes at the starting line turned and went back to the shore. The Indians got out and started pounding the oarlocks tighter, removing cross-bars, and otherwise giving the craft a going over. Then the other turned back and the same thing happened. The crews were shuffled about and bedlam reigned.

We were almost giving up hope of having a race when they announced they were ready. By this time it was nearing sunset. However, four canoes floated up to the starting line. Then a canoe with an outboard motor went to a point about two miles out in the lake. The canoes were to round this spot and return to the starting line.

The old lady has the most beautiful smile at Oxford House. The young woman holding baby is 17-year-old mother who won women's boat race.

At the word "Go" the paddles flew and the water churned. They made the four-mile round trip in approximately 10 minutes. Near the finishing line an oarlock broke on one of the boats but the contender made a magnificent effort to keep in the race. To thundering cheers the first canoe swished across the finishing line, a few inches ahead of the others. The flushed victors received the prize money and the applause of the spectators.

Next, a race of the same type was held for women. They didn't make one quarter the fuss that the men had made. Six canoes were entered. A tall, handsome old lady of 60 was at the oars in one canoe and we were all cheering for her. The "rounding point" was moved in a little closer and within minutes the race was on. It was very good. However, our fine old lady was beaten by a 17-year-old mother.

Two amusing races were held next. In the first, one person was in the bow of each canoe. It is so easy to lose control in this case. The canoes would swing around and bang each other. In fact, this hindrance was apparently part of the game. The ones that fell behind at the beginning of the race attempted to bunt the winning canoes as they returned and put them out of the race, too. I was watching the women's race through field-glasses and was astounded to see, in one of the canoes, a mother who ten days before had been delivered of a son. I was a little worried about her but she was laughing and shouting with the rest. No harm was done as she was the first to drop out of the race when she lost control of her canoe. She paddled back to shore before her friends started bunting the canoes which had rounded the half-way mark. But imagine a white woman entering a canoe race under the circumstances!

After the canoe races the crowd moved to the field behind the Hudson's Bay post and there foot-races were held for the young folk. This was followed by a "candy kiss throw" for the little ones. What a mad scramble that was!

At 10:30 p.m. the day was wound up with a football game between the Indians and the whites. Considering that none of the latter had played football in years, they did very well against the Indian youths who practise all throughout the long summer evenings. We were defeated two to one.

Everyone went home, as the old saying goes, "tired but happy" at midnight. Streaks of pink were still visible in the twilight sky. Treaty time was over for another year.

Picnic Package

The success of a picnic depends largely on the food that is taken along. A day in the out-of-doors sharpens appetites and makes meal-time an important event. Fresh vegetables can be kept crisp and moist by packing them in a covered glass jar, plastic bag, or waxed paper. Some standard picnic items that always help fill the bill include hard-boiled eggs, cheese, tomatoes, lettuce, celery, and fruits.

It is because nations tend to stupidity and baseness that mankind moves so slowly; it is because individuals have a capacity for better things that it moves at all.

—GEORGE GISSING

The Nurse and the Law

CARL LEDOUX

(Conclusion)

IN CRIMINAL INVESTIGATION it is the detail which counts. The efficient detective officer must have a fully developed sense of observation, some imagination, a logical well-ordered mind, good general knowledge, a fund of experience upon which to draw, and a painstaking thoroughness which does not take into account the time and labor spent, but only the solution of the problem in hand.

He must be devoid of preconceived ideas or "hunches" and capable of long hours of fruitless effort without being discouraged. The brilliant detective, who can solve the most complex problem in a dramatic radio murder story within the allotted half-hour program, is, as his role implies, merely a figment of the script writer's imagination.

Perhaps I might add a few more remarks relative to post-mortem procedure. It is most desirable that a sample of the deceased's blood be taken for "grouping." This is necessary in the event we may later find a suspect with blood-stained garments. Should the blood be of a different group to the suspect's, but of similar group or type as the victim's, the fact would be of considerable value in evidence. If the victim has not been "grouped," and the body is embalmed and interred, we have no direct method of getting this information, unless of course he had a transfusion before death overtook him or there is some other authentic record.

For similar reasons we would also like to preserve a small tuft of the deceased's hair. During investigation, a blood-stained stick or bludgeon with a few hairs adhering to it may be found. It will then be necessary to have a comparison made with the deceased's hair through microscopic examination.

In cases of death by drowning, a technique has been worked out by Dr. Gettler, chief medical examiner for the city of New York, which determines whether the victim actually drowned. In New York there are numerous instances of gangland murder where the victim's body is disposed of in the Hudson or the East River. For the proper investigation of the case, it is necessary to determine whether the victim actually drowned or was dead before immersion. Dr. Gettler's technique determines whether the victim was breathing at the time of submersion. The theory is that a person who is still breathing when immersed will inhale quantities of water. There will be a dilution of blood in the left side of the heart and, if the drowning occurred in fresh water, the chloride content of the blood in the left side of the heart will be lower than that in the right side. Conversely, if the drowning occurred in salt water, the additional chlorides in the sea water will increase the left heart blood chloride content over that of the right side. Should both sides of the heart have the same content, it is reasoned that the victim did not inhale water at the time of immersion. This test is more indicative than conclusive. Dr. Alan R. Moritz, professor in the Department of Legal Medicine of Harvard University, has done some further research in this connection and utilizes the magnesium content of the blood as a more critical indicator, as well as the chlorides.

The identification of the dead frequently presents monumental obstacles. We rely, of course, a great deal on finger-prints. Where the identity of a body is in any doubt, post-mortem finger-prints are taken which are later compared with existing records, both in our own Finger-print Section at headquarters and in those of the national capitals at Ottawa

and Washington, D.C. During the war, many people were finger-printed for security reasons who had never been convicted of any offence. These records are naturally kept entirely apart from the criminal ones, but are available for the identification of the dead, if necessary, and are invaluable in tracing victims of amnesia and others who may have temporarily lost the use of their faculties.

Of course many people have never been finger-printed so other means of identification have to be used. Accurate descriptions are taken, showing apparent age, both from appearance and from autopsy, height, weight, color of hair and of eyes, birth-marks, scars and deformities. Operative scars are often of great value and x-rays reveal old fractures which will help in making an identification. Photographs of the deceased are taken but, more often than not, these are of doubtful value due to post-mortem changes and other conditions which alter the appearance of the dead. The recent fad for tattooing is of some assistance, though not too reliable. The same design is used over and over again on many people and so cannot be considered as conclusive without other supporting identification.

One of the most effective methods of identification is through dentures. In cases where the victim has been rendered unrecognizable through decomposition or where he has been the victim of a conflagration, the denture is often the only means of identification. An examination of the deceased by an experienced dentist will often supply a great deal of information concerning the unknown. A plan or chart of the mouth is prepared, showing extractions, fillings, and other repair work, with notations on how long before death the work was performed. Information of this kind circulated among members of the dental profession has at times brought excellent results. Most dentists keep a chart of their patient's dentures and can usually recognize their own work. It is very rare for two persons to have the same dental plan involving extractions and repair work. Materials used for repair are also an indication, such as gold fillings, amalgam, and so on.

Chronic organic disorders concerning which the deceased must have consulted a physician during life are also valuable in circularizing the profession.

Any label or tag, as well as cleaner's and laundry marks found in the clothing of the unidentified dead, are traced through trade organizations. In fact every possible channel of inquiry is probed in an endeavor to ascertain the identity of the deceased, which includes a perusal of all files of missing and lost persons covering an appropriate period.

Occasionally a patient is brought to the hospital in a dying condition and, before he passes away, makes a statement concerning the cause of his death. This statement may be invaluable to the investigation and presentation of a criminal case. However, not all dying statements are admissible in court and we should, therefore, examine the requisite elements. An ante-mortem statement will only be admitted in a charge dealing with the death of the person making the statement. He could not, for instance, make an admissible statement concerning a robbery he witnessed if he were dying, say, of pneumonia.

The next ingredient is that the person making the statement must have a positive and hopeless expectation of imminent death and that this information shall have been imparted to him by a person with authority, usually a doctor. The statement can only include admissible evidence—that is to say, evidence which the person would be permitted to give if he were actually in court himself. This naturally excludes from the dying declaration any hearsay evidence and so forth.

The statement should be taken preferably before a justice summoned to the death-bed for this purpose, but if there is no time the doctor or nurse is justified in taking it. A notation should be made of the time, date,

place, the number of persons present and who they were, and what information was given the deceased touching his condition before he made the statement. All this will be required when the Court is asked to admit the evidence. The statement should be written out as nearly as possible in the words of the dying person and, if he is able, he should be asked to sign it. Witnesses will also mark the written record in such a way that they will later be able to identify it, usually by signature. The theory upon which a dying declaration is admitted in evidence is that a person about to die, with no possible hope of recovery, will tell the truth before expiring.

In the case of a woman dying as a result of criminal interference with a pregnancy, who makes a statement before she passes away implicating the abortionist, the statement could *not* be used on a charge of abortion against the culprit but, if the conditions previously mentioned have been met, it *could* be used on a charge of murder or manslaughter. The culprit would usually be charged with murder.

In the public interest, it is very necessary that those charged with the enforcement of the law be given every possible assistance in tracing and prosecuting the many unscrupulous, callous, and inefficient individuals who practise their nefarious trade on the worried and ignorant expectant mothers. In some quarters there appears to be a friendly feeling towards these harpies of a restless civilization. They are endowed with an aura of beneficence. Young women speak of being "helped out" by Mrs. So-and-so, but the help they receive is always for a cash consideration—a consideration which may even cost them their lives. The abortionist is usually an untutored and reckless person who knows that, while the physician spurns their dirty work, he will not stand idly by if the unhappy victim of their interference develops septicemia and has to be admitted to hospital. Should the worst happen and the patient die, the culprit relies on the secrecy of those concerned and on the victim's mistaken sense of honor. Any help you can render in putting the abortionist out of business will be a valuable contribution to the community's well-being.

Before I close, I would like to add one more point in the matter of statements. Under our law, if a woman is the victim of a sexual assault, evidence may be introduced concerning her first report of the attack and what she said at the time. It is necessary, however, that the statement shall have been made at the first available opportunity. A delay of a day or perhaps of several hours may render the statement inadmissible if the victim had the opportunity of reporting the occurrence before that time. The theory on which the statement is admitted is not to corroborate the *truth* of her allegation but rather to show that her first statement, made at a time when the events were still fresh in her mind, is consistent with the story she later tells in court. Actually it is a test of the demeanor of the ravished woman immediately after her assault.

It is quite possible that some day any one of you may be in the position of receiving such a complaint or statement. In that event, you should remember to note the time, place, date, and the physical condition of the girl when she first came to your notice. Particular attention should be given to the condition of her clothing, whether she still has her shoes on and so forth. In fact anything of an abnormal nature should be noted. The statement should be taken down as closely as possible in her own words. It is not necessary that there should be another witness to a statement of this kind.

I will close with this one thought. A single paper match, torn from an ordinary match booklet, may be the one piece of evidence placed on the scales of justice which will tip the balance and convict an enemy of society—your enemy. Will you help us fight that enemy?

The Teddy-bear was named after Theodore Roosevelt because he had a small bear as a pet.

Aims of Professional Education

MARY E. HENDERSON

Average reading time — 8 min. 6 sec.

PROFESSIONAL EDUCATION is rather an indefinite, abstract subject, and one in the development of which many profound theories could be presented. However, my approach will be very simple, clear, and straightforward. In order to treat this subject at all satisfactorily, we should agree on what we mean by a profession. There used to be just three learned professions—theology, law, and medicine. Of these, medicine, in spite of the fact that there were great physicians in ancient times, has come into its own only comparatively recently. Today, there are many other professions to be added—dentistry, engineering, social work, teaching, and nursing, and perhaps others may be added to the list.

The definition of the term "profession" has been attempted many times and seems to be a point of some difficulty. The definition given by Dr. Cottrell[1], dean of the College of Education of Ohio State University, seems to be as simple and clear as any other. It reads:

> A profession is a voluntary association of people devoted to the promotion of human welfare through the practice of an art based upon scientific skill and understanding. Professions come into being through the efforts of the members of an occupation to build their work upon a firm foundation of expertness and to see to it that their common effort benefits society.

Let us analyze what is implied in this definition.

First, a profession is an occupation which aims at *some benefit to society.* The professional worker must care about human welfare in his work. Each profession has an important social task to perform which contributes directly to the common welfare. Candidates for a profession, it naturally follows, should be persons of high moral purpose and of unselfish aims.

A second implication of the definition, and the one regarded as the most distinctive and essential characteristic of a profession, is that it depends for its practice upon *a well-organized body of scientific knowledge.* Although a profession is a practical occupation, it cannot be carried on without a knowledge of scientific principles and theory, obtained usually in a professional school or university under competent instructors. The professional worker must have skills but these skills must be combined with and rest upon theoretical knowledge of scientific principles.

The members of a profession are chiefly responsible for the *standards* of their profession. Through their professional associations, standards of efficiency, as well as the social status and the material prosperity of members, are maintained and raised.

Let us relate these attributes of a profession to our own field of nursing. We can truthfully say that nursing has an important social task to perform which contributes to the promotion of human welfare. Nursing may be said to be an art based on scientific skill and understanding. Nursing associations are very interested in maintaining and raising their standards—in protecting their members and giving a high standard of service to the public. In all these respects, nursing meets the requirements of a profession.

Nursing is a very new profession—it has been called an emerging profession by educationalists. Some of the respects in which it lags in comparison with other professions will come to light if we consider the evolution of professional education. Samuel Capen[1], a noted American educationalist, described four cycles through

Miss Henderson is educational supervisor with the Metropolitan Health Committee, Vancouver.

which professional education has passed. The first was the cycle of apprenticeship. For a time the apprenticeship system proved effective but, generally speaking, it failed in producing the quality and quantity of required professional workers. We must admit that to some extent nursing is still partly in this stage—certainly more than all of the other professions mentioned.

The second is described as the cycle of expansion when professional schools sprang up to supplement apprenticeship. Often they were inadequately equipped and imposed no educational requirements on the students.

The third cycle was one of regulation and standardization, with the educational institutions and professional associations setting up standards and obtaining governmental authority for enforcing them.

The fourth cycle Mr. Capen describes as the cycle of critical analysis in which there is analysis of professional activities, standards of practice and education. In Mr. Capen's opinion, nursing is going through all these cycles at the same time. Today, it can be said that nursing leaders are everywhere carrying on an analysis of education for the different fields of nursing and of the needs of present-day society for types of nursing service. They are also considering the rewards and satisfactions of the student and graduate nurse.

General educational requirements for entrance to professional schools is another point which should be mentioned. Educationalists consider the fundamental task of general education is to produce well-balanced students, ready to take a significant, useful place in society. The expression "Education is the key to an abundant life" has been used. It is universally accepted that a good general education should precede professional education. In this instance again, we must admit that educational standards for entrance to nursing schools are below the level of those of other professional schools. Most professional schools require at least two years of university education before entrance to their own schools or their preparation is received entirely at university level. There still are instances in nursing of where educational standards are below high school graduation.

Up to this point, we have spoken of the meaning of the term "profession" and all its implications and of the evolution of professional education. With these remarks as a basis, let us now turn more closely to the heart of our topic. Dr. Cottrell, also sets out the three principal obligations of professional education. They are:

1. To provide a supply of workers at a defensible level of competency to meet the reasonable requirements of society for the popular service.
2. To guarantee the technical, scientific, and artistic proficiency of all practitioners above a determined minimum.
3. To lay a basis for and to foster the emergence of leadership among all practitioners, both in the improvement of the practice of the profession itself and in bringing the special contribution of the profession to bear upon the general social situation of the time.

To reduce these to very simple terms, we may say that the main aim of professional education is to produce an adequate supply of competent scientific workers to meet the needs of society. Professional education should foster qualities of leadership so that the necessary numbers of professional members will accept leadership and work towards maintaining and improving their professional standards and assuring that the needs of society are met. With these aims we would all agree.

To consider further the question of maintaining an adequate supply of professional workers, we know from experience in the nursing field that this is a very difficult problem. Among other things, it entails a careful estimation of overall needs and recruitment of a sufficient number of desirable candidates. At one time the supply of nursing students was left entirely to chance, but in recent years an endeavor has been made to encourage recruitment and

to expand schools of nursing more in line with the needs. We all know something of the efforts of our national and provincial associations in the student recruitment program and in raising standards of nursing schools. Certainly we realize, too, that all types of professional education have too vital a connection with the public welfare to be left completely unplanned and unregulated. The distribution of workers according to needs, in urban and rural areas is another difficult matter. Unequal distribution of doctors, nurses, and teachers in these areas has long been a serious problem.

Professional associations are a'ive to all these problems and are endeavoring to work towards solving them. An encouraging fact is that we can say today that the government and our citizens generally are taking a far keener interest in all these questions and are uniting with the members of the professions in demanding expansion and betterment of all public welfare services.

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In the Good Old Days

(The Canadian Nurse, August 1910)

"The medical inspection of schools is of very ancient date; the Egyptians and Grecians had teachers skilled in the art of curing, who looked after their pupils. Then we hear very little of it until 1842, when the laws of Paris ordered that all the public schools should be visited by a physician, who would inspect the school children and the buildings . . . In 1894 the London County Council had nurses visit their schools and take care of any minor contagious diseases among the children . . . That same year, Boston appointed medical inspectors, who inspected the schools regularly. In 1895 the program was introduced in Chicago. In New York, it was brought about by an epidemic of scarlet fever which was caused by a small boy pulling pieces of skin from his hands and passing them to his playmates."

* * *

"There are as many different kinds of nurses as there are kinds of people—everyone has a different nature. The first essential of being a good nurse is to be a womanly woman. The reason we hear of indifferent nurses is that, as a band of women, we stand or fall together. If one nurse is found indifferent to the claims of her profession, we are all criticized and put down to that same level."

* * *

At a special meeting held in Toronto on May 25, 1910, Miss M. A. Snively moved "that this meeting of representatives of the combined associations of trained nurses do hereby resolve that there be formed and organized the Canadian Branch of the Army Nursing Reserve."

* * *

"Vancouver is preparing plans for an isolation hospital, to cost not less than $20,000."

* * *

"In April, the graduate staff of the Montreal General Hospital gave a 'weighing party,' the proceeds to form a nucleus for a Sick Benefit Fund. The party was a great success and over $300 was realized."

* * *

"Last year (1909) carefully prepared regulations were issued and each hospital for the insane in Ontario, to which acute cases are admitted, was required to establish a Training School for Nurses. A three years' course of study was decided upon so that at each institution a uniform system of instruction would be followed."

Washing Windows — Use up-and-down strokes for the outside of the window-pane and side-to-side strokes for the inside. Then, if a mark is left, it is quite simple to tell which side needs the additional shining.

Public Health Nursing

Developing the Social and Health Aspects of Nursing

IRENE LAWSON

Average reading time — 4 min. 48 sec.

Note: The W. K. Kellogg Foundation offers scholarships to certain Canadian universities to assist in preparing faculty in schools of nursing. Miss Irene Lawson, assistant superintendent of the Victorian Order of Nurses in Hamilton, was granted such a fellowship to assist her in strengthening the public health field experience offered in the community to the students of the McMaster University School of Nursing.

* * *

The following are two excerpts from the report written in connection with my three-month travel fellowship. The first is the summary of an interview with Miss Margaret Scanlon, senior supervisor, State Board of Nurse Examiners, New York. This gives some guidance as to how public health nursing personnel can be used in schools of nursing:

The State of New York considers it essential for all schools of nursing, within the state, to emphasize the social and health aspects of nursing in the student program. To meet this need some schools are employing public health coordinators, while others are depending upon present staff to carry out these principles. To assist in this project the State Board of Nurse Examiners has added Miss Scanlon to its staff. The purpose of her appointment is to provide assistance in clarifying and developing the function of health personnel in schools of nursing.

Miss Scanlon discussed the role of the health coordinator, beginning with her early experience as a coordinator when hospitals did not understand the scope or complete value of this addition to their staff, realizing only that it was a step in the right direction to employ such a person. In defining her later findings, she implied that the health teacher must occupy a position comparable with the associate or assistant director of nurses, with equal requirements for qualification and equal salary. To assume an adequate role the health coordinator needs the authority this status provides. She needs a voice in policy-making in order to direct the thinking of personnel in the fields of both education and service. She needs to act as a resource person and to be available to all members of the staff and faculty for resource purposes in order to develop an awareness of positive health that will permeate the whole group responsible for the education of nursing students. She should have opportunity to observe existing policies and have time for developing research.

Effective use of the coordinator must carry the complete understanding of all groups from the hospital administrator downwards. She must have the understanding of the medical profession, the hospital social service, and the outpatient department, where two-way referral systems link the patient and the hospital with the community and the home. Miss Scanlon sees "individual patient care" reaching its full value only when a health consciousness is reached that envelopes both student education and patient service and embraces all hospital departments.

The second excerpt is an account of a case study which was presented by the students of the Department of Nursing of Skidmore College, under the direction of Miss Irene Carn, at an institute for teachers held at Teachers College, Columbia University, on "The Social and Health

Aspects of Nursing in Schools of Nursing." We feel this patient-centred conference is an excellent method of developing the concept of total patient care:

Objectives of this method:

To develop within the student an appreciation of the patient as a person or individual, with family ties and community relationships.

To help the student apply and integrate what she knows of the health and social aspects of nursing.

Mechanics of this method:

The instructor contacts the ward a few hours previous to the conference and delegates one student to bring a case history of a patient for whom she is caring. The student chooses a patient known to the various members of the group, if possible.

The group consists of nurses from the same ward but not necessarily the same year, hence students may be juniors just learning this method or seniors well practised in it. No preparation is considered necessary other than the good day-by-day nursing care that each student is supposed to be giving her patients.

The student selected presents her case history to the group. Another student is asked to lead the discussion.

All students participate in the discussion, bringing to light considerable information gleaned from the patient and his family by the various nurses caring for the patient.

The instructor's role is passive and control is released to the students as soon as the introduction is completed. Assistance, however, may be given the leader in drawing in timid students.

At the close of the conference the narrator is asked to bring a progress report to the next class.

SUMMARY OF CASE PRESENTED

The case history presented was that of a child of three years suffering from eczema. The students discussed the known family aspects and personality traits of the child. They related the present condition to previous attacks, and present care to what the mother might be expected to know and carry out safely. They then drew up a plan whereby the mother would spend a morning at the hospital observing the nursing care and treatment of the malady. The mother would be asked to return a second day to give the care to the child under the guidance of a nurse.

A plan was set up to contact the visiting nurse association for supervision in the home; to contact the doctor for dismissal of the patient and orders for the V.N.A.; to contact the nutritionist to interview the mother; and to contact the out-patient department for a return appointment for the child. A memo would be posted on the ward regarding this appointment so that a student might see the child at this time. It was felt that guidance should be sought in the community, possibly through parent education classes, to enable the mother to better understand the personality problems of the child handicapped by recurrent illness.

Evaluation of this method:

1. The focus is centred upon the patient as the primary source of information.

2. The currency of a case is the satisfaction to the student.

3. The student relates one fact with another within the case and recognizes the relative importance of the collection of facts as considered by the group.

4. The student begins to apply and integrate what she knows of the health and social aspects from any source—her home, her life, her lectures, and good basic knowledge.

5. The student begins to relate this experience to good nursing care and learns to formulate a plan of care for each patient.

6. Student growth is promoted to a degree that warrants the use of valuable time in this type of learning situation. The student develops:

(a) a widened point of view;

(b) a capacity for recall, comparison, and judgment;

(c) an ability to present material and express herself orally;

(d) an ability to think constructively and objectively through group participation;

(e) a greater confidence in herself.

7. The rapport established by the faculty and students, thinking and planning together, has definite value in student development.

Private Nursing

Hidden Diabetes with Psychosis

CHRISTINE MACLEOD

Average reading time — 5 min. 36 sec.

MR. ABEL, a postal clerk, aged 59, awoke July 3 feeling that something was terribly wrong! As he expressed it later during his convalescence, "I couldn't think." His wife said he went into a sort of coma. By noon he was muttering incoherently, making useless motions with his arms, and while still in a comatose condition his family physician sent him to hospital to be under the care of a neuropsychiatrist. Preliminary diagnosis on admission was: (1) manic-depressive psychosis; (2) pre-senile arteriosclerosis.

His condition was poor. He was uncooperative, incoherent, resistive, even violent at times, refusing all food and fluids. Blood pressure (116/90) was normal though it is often elevated in arteriosclerosis. History was negative with no report of previous illnesses. Mr. Abel was of an athletic build. The only peculiarity of his dietary habits was that he disliked all sweets and desserts.

The day before admission he had been unusually quiet and complained of his right leg being cold in spite of the warm, dry July weather. His yearly holiday had just begun and he had spent the day before mending the roof of his home. That evening after supper he just sat staring into space. Later, for no reason at all, he had a weeping spell. Mrs. Abel and their two grown sons thought he was overtired and he retired early.

During the first few days of hospitalization there were marked episodes of excitement and confusion with memory impairment, disorientation, inability to think or concentrate.

Laboratory findings: (a) Urinalysis—Sugar plus 3. In health, no sugar is present in the urine; (b) Fasting blood sugar—228 mgm. In health the normal ranges 80-120 mgm.

Insulin therapy was begun with daily blood and urine tests. Mr. Abel received varying amounts of insulin to control the diabetic condition. Discoloration of the right leg and foot was noticed at this time and the limb was cold and numb. Coordination was poor. He was unable to grasp or hold anything with his right hand. He remained untalkative but during quiet periods he seemed to be in pain. It was noticed that the right foot was becoming cyanosed, accompanied by pain and swelling. A continuous ice-pack, reaching from the foot to above the knee, was ordered, which greatly relieved the pain. At the same time a partial paralysis of the right arm and hand was observed. This was believed to be due to a cerebrovascular accident, occurring simultaneously with the thrombosis in the right leg.

On July 9 a venous ligation was done on the right leg. Following this ligation, Mr. Abel became quieter and more cooperative. He was, however, still confused, speech was abrupt, coordination poor. With daily insulin his appetite improved. Encouraged to feed himself, he often gulped down his food, scooping it up with his left hand since he was still unable to hold a spoon or fork with his right hand. In the next few days his mental condition cleared considerably. On

Mrs. Macleod works at the Royal Jubilee Hospital, Victoria, B.C.

July 16, Mr. Abel was transferred to the general hospital, as surgery on the right leg seemed inevitable.

Laboratory findings: July 17 to July 30.

(a) Urinalysis—Negative for sugar.

(b) Blood-urea-nitrogen—July 17, 36 mgm.; July 19, 37 mgm.; July 21, 19 mgm. In health the normal ranges 10-20 mgm.

(c) Fasting blood sugar—170 mgm., gradually reducing to 137 mgm.

On July 17, following consultation, amputation of the right leg above the knee was decided upon. The ice-pack was kept on continuously even after the orthopedic preparation of the area. The operation was performed under cyclopropane anesthesia on July 18. The patient reacted normally, his chief request being "Chuck in more ice." Sensations of pain persisted for some time after the amputation.

Treatment

Morphine sulph. gr. 1/6 by hypo for pain p.r.n. Foley retention catheter for the first 8 days. Penicillin units 100,000 every 3 hours, intramuscularly. Daily blood and urine tests for sugar. Clinitest for sugar in urine was done on the ward before each meal. Protamine zinc insulin once daily, plus unmodified or crystalline insulin, the dose regulated to control the diabetic condition.

Diet: Liquids freely (diabetic); 2nd day post-operative, light diet; 4th day, full diet. *Diabetic formula:* P. 100 gm.—F. 40 gm.—C. 210 gm.

During the first post-operative week, the patient was restless, irritable, and resistive, sometimes fearful and emotional. Great tact was required of those caring for him. Especially at night he became hyper-emotional—singing hymns or weeping. At other times he had delusions of persecution, asking why he was being punished—begging his nurses to tell him what wrong he had done. Mr. Abel's night nurse (a registered male nurse) used to call him by his first name and discuss the current baseball scores, which seemed to afford the patient great satisfaction.

The patient's family were allowed to visit him daily although he did not recognize them until the third day after the operation. As he often wept and begged them to take him home their visits were quite short. On the third day after the operation, July 21, Mr. Abel asked, "Is today July 4th? I know I was sick on July 3rd." This was one of the first hopeful signs that his mind and thoughts were clearing. Another good sign was a return of his sense of humor. He would make short, witty remarks which the family said were characteristic prior to his illness. With orientation re-established, improvement was rapid. Appetite improved, coordination was better. Mr. Abel slept well and sedatives were no longer necessary. Incontinence occurred less frequently. He was very sensitive regarding the loss of his leg and required constant reassurance. He was forgetful and almost daily wanted an explanation of his illness; the diabetic condition, why the amputation had been necessary, and how soon he could return home; how soon could he be fitted with an artificial limb and resume his former employment? He was encouraged to use his right hand and was proud of his improved accomplishment. The diabetic diet he found amusing, often encountering strange salad combinations which he had never eaten before.

The stump of the right leg healed without complications and during the last week before discharge Mr. Abel was allowed up in a wheel-chair for short periods each day. He was instructed about his diet, but the chief responsibility for checking and weighing his food was given to Mrs. Abel who spent hours sitting in his room studying the diabetic manual and consulting with the dietitian. The necessity for daily urinalysis and regular check-up with the family physician was also stressed.

Psychotherapy and Rehabilitation

The nature of his illness was explained to Mr. Abel. He was given constant reassurance to allay his fears. Praise for successful efforts in feeding himself and getting into the

wheel-chair helped to restore self-confidence. He was gradually prepared for the idea of an artificial limb and his desire to return to work was encouraged. His interests were rather narrow outside the home, being chiefly his work, the daily newspaper, and the local baseball team. An effort was made to interest him in handicraft and in more varied reading. The family eagerly accepted suggestions and greatly assisted in the patient's adjustment and rehabilitation. On the day before discharge Mr. Abel was seen by the same neuropsychiatrist who first treated him and who now pronounced him normal. This was on July 30, just 28 days after the onset of his illness and 12 days after the amputation.

Hidden Diabetes with Psychosis—3

Two months later, Mrs. Abel wrote that her husband was now entirely well. He was getting about on crutches, could use his right hand perfectly, had been measured for his artificial limb, and was very anxious to return to work. He was having insulin daily and following the diet faithfully. By the middle of October he was fitted with his leg and learned to walk with a cane. His only reference to his illness and hospitalization was "It's lucky I was sick in July and August and did not have to miss the baseball world series broadcasts."

Final diagnosis: Diabetes mellitus; endarteritis obliterans, right leg; psychosis due to pathological intoxication; amputation, right leg.

Conclusion

This study seems to emphasize the importance of regular physical check-up. This is of even greater importance after the age of 40, when latent or hidden conditions may be found. Following a survey made in Oxford, Mass., October, 1947, the U.S. Public Health Service reported: "For every four known cases of diabetes, three more previously undetected and unsuspected were found through the survey."

Mr. Abel had called the family physician to see members of his family at various times but stated that, as he was always in excellent health, he had never had a physical check himself. A note from Mr. Abel's doctor two years after his illness states: "I saw Mr. Abel recently. His mental state was good and his diabetes was under good control. He is continuing to take insulin."

Epilation

At the present time there is no known drug that will cure hypertrichosis. The only method available for permanent removal of hair is, therefore, the destruction of the papilla and papillary vessels. Widely advertised depilatories only dissolve the hair shafts, never penetrating deeply enough to destroy the hair-producing papillae, and for this reason afford only temporary improvement. Nevertheless, women make extensive use of these preparations, not only because of the simplicity of their use but because, to their knowledge, no other method is available. Depilatories may prove very irritating to the skin. The mechanical friction and irritation of depilatories and pumice stone serve to stimulate the hair papillae, so that the result obtained is not only coarser hair but hair which is more resistant to epilation by desiccation. Removal of hair by epilation forceps is likewise only a temporary measure, as the hair rapidly regenerates.

The best way to prevent accidents to the eyes is to wear glasses. A fact well known to eye physicians is that it is a rarity to have a man injured by broken glass from his spectacles. The missile that breaks the glasses usually expends most of its force on the lenses or frames and the eyes receive little or none of it. It is also true that an object that hits the glasses gets such a sharp reflex act from the eyelids that, when it goes through the glass, it hits a closed eye instead of an open one and the sight is saved.

Institutional Nursing

The Value of Visual Aids

SISTER M. ROSARIE

Average reading time — 8 min. 6 sec.

IN THE REALM of education it is quite evident that, for the majority of people, the concrete picture is much more effective in the learning process than simple verbal instruction. Actually, this is just another way of stating the well-known axiom—"One picture is worth a thousand words." The concrete picture is one of the most effective means of preventing verbalism. According to Hoban, verbalism may be defined as the generic term applied to the use of words without appreciation of the meaningful content of the words or of the meaningful content of the context in which they are used[10]. Teaching on an abstract level is usually the cause of this condition and consequently the student fails to grasp a complete understanding of the subject taught.

To overcome this difficulty concrete visual materials, known as visual aids, are receiving ever-increasing attention in the field of education. Naturally enough, history teaches us that illustrations came before the written word. Apparently the caveman felt the necessity of recording his ideas by drawings before he could read or write. This is perhaps our first introduction to visual aids. Visual education, if it is to be effective, should stimulate the imagination, arouse the interest, clarify ideas, as well as build up habits of independent study. Progressive educators in general are cognizant of these facts and are introducing well-organized visual programs as part of the school curriculum.

In keeping with these modern trends in education, the nursing profession has gone forward by taking advantage of changing methods of teaching and by utilizing scientific knowledge. In the classrooms of the nursing school the use of visual aids fills a very definite need. Although the value of visual education is now well established, there are very few references to its use in nursing textbooks or in nursing journals. The purpose of this paper, therefore, is to enumerate some of the practical methods of visual education in the nursing school program and to emphasize the importance of correlating this material with the school curriculum.

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TYPES OF VISUAL AIDS

Visual materials, which may be found valuable in the school of nursing, include field trips, models, specimens, objects, motion pictures, still pictures, and graphic material. These types are listed in their order of importance from the most concrete to the abstract. From this classification it can be readily seen that the *field trip* is the most concrete, as the student is brought into direct contact with the situation to be studied and is able to observe the various relationships as they actually exist. The field trip for the nurse can be the hospital ward, a visit to a clinic or to another hospital where first-hand experience can be gained.

Models, specimens, and objects are so universally used that they need not be discussed at length in this paper. A *model* is a replica of an object or a representation of the object in miniature. Perhaps one of the best examples of a model is the well-known Chase doll.

A *specimen* is a sample or part of an object. Among the specimens used in the nursing school classroom are the heart, brain, bone, and various other organs. The demonstration of the specimens is usually accompanied by a lecture and this is essential for the proper understanding of the lesson.

An *object* is something brought from its natural setting into the classroom. Various types of trays used on the hospital ward represent this type of visual instruction. Needless to say, the use of models, specimens, or objects supplies the type of experience that will make the lecture meaningful.

The use of *sound motion pictures* is probably the most popular kind of visual instruction in so far as the student nurse is concerned. It is true that this kind of visual education is not considered as valuable as actual observation, yet its importance as an excellent teaching device is well recognized. During World War II the use of motion pictures for teaching was quite general when accelerated programs had to be carried out for large groups[13]. In showing motion pictures there are psychological factors which enhance the desired result. Projecting films in a darkened room tends to focus the attention of the student on the screen by eliminating distractions. The rapid action and continuous changing of events are also effective in arousing and sustaining interest. A question frequently discussed is whether the motion pictures should be shown to the group at the beginning or at the end of the unit taught. If the purpose of the film is to arouse interest and raise questions, it should probably be shown early. If the purpose is to give an overall review of the unit it would seem more logical to have it at the end of the instruction.

Still pictures include *photographs, photographic slides, and filmstrips.* When these aids are accompanied by didactic instruction the student gains a mastery of the subject in a much shorter time. All three methods of teaching can be used on an all-purpose or a tri-purpose projector. This type of projector is very convenient and is recommended for all nursing school programs. The simplicity with which an illustrated page can be shown in the course of a lecture to clarify an idea or to demonstrate a fact makes this instruction particularly useful. Photographic slides are also a great asset but they require more careful attention in handling and projecting.

Graphic material — that is, recording facts by means of graphs — is the most abstract form of visual aid requiring a fuller explanation for effective teaching. Graphic material, however, has a very definite place in the hospital field. The two most common forms of graphs used here are the line graph and the bar graph. The line graph is used on the patient's clinical record to show temperature, pulse, and respiration. The bar graph is also often used on this record to report the intake and output of fluids. It is one of the best means for the visual comparison of quantities. Different colors may be used in making these graphs to create increased visual attention to the chart.

These different types of visual aids do not cover the entire field but embrace the essential requirements for successful teaching in the nursing school. One could go on enumerating almost endlessly the many ways that instructors can make use of visual instruction. It must be remembered, however, that visual aids are merely supplementary devices and must be correlated with the school curriculum. In this connection read Heidgerken[8]'s excellent article on the necessity of the proper organization and administration of an audiovisual education program. In the past, unfortunately, this fact was often overlooked when visual aids were not correlated with other instructional material. For example, motion pictures would be shown to a group of students when the films were readily available but irrelevant to the teaching program at that particular time. With this type of instruction it is quite apparent that visual aids contribute

little, if any, to the objectives of the course.

SUMMARY

The importance of visual aids in the nursing school program has been emphasized. Visual aids being concrete in nature enrich the experience of the student and greatly facilitate verbal instruction. However, if this method of teaching is to offer a significant contribution to the learning process it must be organized and properly correlated with the nursing school curriculum.

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A Recruitment Idea

An ingenious group of nursing students at the Saskatoon City Hospital School of Nursing recently entertained prospective applicants at a novel tea and display. Under the caption of "Prelude to Nursing" an attempt was made to demonstrate, through posters and other exhibits, a fairly complete picture of the activities of a student, both on and off duty. Throughout the afternoon, school of nursing students conducted over a hundred enthusiastic guests through the classrooms, explaining the displays and answering myriads of questions. Particular interest in a display by the obstetrical department was evident. This included a modern incubator, information on baby feedings and infant care. The children's ward exhibit centred largely around play interests. Another popular display was the operating room scene with large dolls dressed as doctor, nurse, and patient, complete with incision. The emergency department depicted a well-splinted accident victim receiving prompt attention.

Star-Phoenix Photo, Saskatoon

Is it real?

As the idea was to stimulate an interest in nursing generally and to make applicants aware of the advantages offered in various schools of nursing, a display of calendars,

(*continued on page 667*)

Aux Infirmières Canadiennes-Françaises

Les Aides dans l'Equipe en Nursing

ANNE HAHN LINDBLAD *et* MILDRED STRUVE

Average reading time — 24 min. 38 sec.

(Suite de l'édition de juillet)

RÉSOLUTIONS ET PROJETS

Après 18 mois d'essai, l'opinion générale du personnel infirmier était que les services des aides, étant des plus appréciés, devaient être continués et organisés dans tous les départements. L'organisation de ce programme dans chaque département a demandé une énorme dépense de temps de la part des institutrices, à cause de la répétition du programme d'enseignement. Les meilleurs résultats furent obtenus en limitant les classes à des groupes de six ou huit, au maximum dix. Avec un plus grand nombre, le temps alloué à la surveillance de la pratique individuelle devait être fixé en dehors des classes d'enseignement. Les discussions et questionnaires étaient plus spontanées lorsque les groupes étaient actifs, facteur de première importance dans cette enseignement.

Les institutrices régulières des écoles d'infirmières n'étaient pas toujours disponibles à former un nouveau groupe d'aides, pour la raison que ces classes ne devaient pas interférer avec le programme d'études des étudiantes infirmières. Par conséquent, notre plan fut modifié comme suit:

1. Une institutrice à temps complet ou partiel, selon la nécessité, fut chargée de ce programme pour tout l'hôpital. Elle est responsable de la majeure partie de l'enseignement et de la surveillance individuelle. Elle doit être un agent de liaison entre les différents départements, répondant à leurs besoins, communiquant avec le département du personnel pour s'assurer des candidates qualifiées. De plus, elle explique le programme aux nouveaux groupes d'infirmières professionnelles et revise de temps à autres les activités des aides avec les infirmières en chef des divers départements.

2. Un programme de classes et de démonstrations d'une période de trois semaines, excluant le temps consacré à la surveillance individuelle, est donné à toutes les aides. Ceci nécessite l'accès aux salles d'étude afin que les groupes d'aides puissent commencer le programme d'entraînement en général à différentes époques. Les instructions et directives spéciales, qu'il faut ajouter à cause des différents besoins de chaque service, sont laissées à la discrétion de chaque département. Les classes commencent la première journée de l'emploi et se continuent environ un mois. Ce temps varie quelque peu selon le nombre du groupe et leur facilité d'assimilation. L'ordre des cours est tel, que l'aide peut se rendre utile dès le premier jour et devenir de plus en plus compétente à mesure qu'elle est formée et dirigée.

3. Une liste des activités, approuvées pour les aides, est affichée dans chaque salle de même que la cédule des classes et de la surveillance pratique lorsque les nouvelles aides ont reçu leur entraînement.

4. Il est désirable d'avoir dans le plan

La traduction de ce volumineux article, publié en premier lieu dans *American Journal of Nursing* (jan. 1949), a été faite bénévolement par l'Hôtel-Dieu de Montréal.

Mme Lindblad est administrateur assistant et chef de nursing ophtalmique à l'école d'infirmières, l'Hôpital Johns Hopkins. Mlle Struve, autrefois administrateur assistant at chef de nursing médical à Johns Hopkins, est maintenant à l'Hôpital Marine, Seattle, Wash.

d'ensemble des aides masculins; d'éliminer les infirmiers en assignant les ménages aux commissionnaires. Ces aides masculins devaient assumer les mêmes responsabilités dans le service des hommes que les aides féminins chez les femmes. Il nous fut impossible de former des hommes aussi compétents que les femmes, raisons pour lesquelles nos efforts ont été concentrés sur des aides féminins. Nous croyons qu'il est beaucoup plus difficile d'entraîner des aides masculins.

L'horaire suivant des classes et de la surveillance pratique est plutôt bref, mais il donnera une idée générale de son contenu. L'enseignement se fait durant cinq jours par semaine seulement. Les 6ième et 7ième jours sont employés à la pratique surveillée et au temps libre. (*Voir programme ci-inclus*)

Les Aides en Service Spécialisé

Nous avons réalisé qu'il était possible d'augmenter les activités des aides en les employant dans un service spécialisé.

Dans le service d'ophtalmologie, en plus des devoirs énumérés dans cet article, on enseigne aux aides à prendre les pulsations et la respiration du patient, d'apporter leur concours dans les divers soins thérapeutiques, et de prendre soin des enfants. Nous avons fait notre première expérience dans cette spécialité.

Une salle du département ophtalmique fut choisie dans laquelle on comptait deux infirmières pour trois aides. Ceci voulait dire qu'à un certain moment du jour il y avait proportionnellement une infirmière pour une aide en service, tandis qu'en d'autres temps, particulièrement sur la fin de l'après-midi et de la soirée, une infirmière pouvait diriger les activités de deux aides infirmières. A l'aide de ce groupe d'auxiliaires, il nous fut possible de donner une moyenne de 3.4 heures de service par patient, par jour, dans une salle d'une capacité de 24 patients dont le chiffre moyen d'hospitalisation par jour est de 20 patients.

En ne tenant aucun compte des dépenses occasionnées par les salaires du personnel, de l'administration, etc., le coût de ce service (en utilisant le groupe d'aides infirmières) fut de $1,350 par mois; par contre, en employant un personnel gradué, le coût pour le même nombre d'heures par jour, par patient, aurait été de $1,800 par mois. On a fait ce calcul en se basant sur un tarif de $180 par mois, salaire de base des infirmières graduées, et $105 par mois, salaire de base des aides-infirmières. Nous sommes persuadées que le succès de l'organisation du programme des aides dans un département quelque soit le genre de service dépend beaucoup de la manière avec laquelle le programme est approuvé et accepté par tout le groupe des infirmières professionnelles, non seulement les infirmières du service général mais aussi les infirmières en chef et les surveillantes.

Après une étude sérieuse des résultats obtenus dans le département d'ophtalmologie, nous avons fait la même organisation dans deux autres salles du même service. Ce système fonctionne depuis deux ans et nous comptons que 61 pour cent des activités en ophtalmologie peuvent être accomplies consciencieusement et avec satisfaction pour les patients par les aides en coopération et sous la direction constante des infirmières graduées — un vrai modèle d'équipe.

Conclusions

Bien qu'il y ait eu de l'opposition de la part des infirmières graduées, nous pouvons affirmer tout de même qu'elles ont apporté une large coopération en préparant et rédigeant le programme; en l'organisant et l'adaptant dans les salles où les aides infirmières sont employées. Il fut reconnu que l'aide infirmière dépensait 100 pour cent de son temps au service immédiat du malade.

On ne doit pas confondre la quantité ou le nombre des soins à donner aux malades avec la qualité de ces soins. Cependant pour assurer de bons soins aux patients, il est essentiel de prévoir des heures additionnelles de service. En raison du manque de personnel chez les infirmières

graduées, ces heures ont été données par les aides infirmières. Le programme de répartition des soins a permis à l'infirmière professionnelle d'utiliser ses connaissances scientifiques et d'exercer son savoir-faire dans l'application des traitements d'un plus grand nombre de patients. Nous croyons que ce plan permettra également de maintenir une meilleure qualité de service tout en assurant le confort du patient.

En tout temps l'aide fait son travail avec l'infirmière professionnelle; la méthode du travail d'équipe est strictement observée. Selon le plan tracé, l'infirmière professionnelle donne ses instructions à son aide, note tous les détails spéciaux à considérer dans les soins des patients, lui recommande instamment l'importance d'accomplir seulement les tâches qui lui sont assignées et la nécessité de lui rendre compte de toutes les réactions extraordinaires des patients. A son tour, l'infirmière en chef encourage l'aide à demander tous les renseignements auprés de l'infirmière professionnelle qui en a la charge. Cette manière de procéder a contribué à renforcir le travail d'équipe qui, par la suite, a réalisé l'idéal du programme: meilleur service des malades.

Les patients des salles, chambres semi-privées et privées ont facilement accepté les services des aides; dans certains cas même, ils ont manifesté un enthousiasme marqué. Ce n'est que par exception qu'un patient s'opposera à recevoir les services des aides, car le public en général est intéressé et compréhensif aux problèmes du nursing et aux efforts que nous faisons pour donner de meilleurs soins.

Le conseil administratif de l'hôpital a fait preuve d'esprit de coopération en rédigeant de nouveaux règlements et en fixant des échelles de salaires proportionnés aux besoins de l'organisation et du développement de ce programme.

Les médecins, les chefs de service, de même que les administrateurs de l'hôpital, ont su reconnaître la qualité des soins donnés par ces employées non-professionnelles et apprécier également la valeur des services de chacun des groupes.

A notre connaissance nous n'avons pas eu de départ parmi les aides-infirmières, ni aucune d'elles n'a cherché à obtenir un emploi soit comme infirmière professionnelle, soit comme infirmière pratique en dehors de l'hôpital.

Dans l'ensemble, la plupart des difficultés que l'on avait prévues au sujet de l'organisation et du maintien de ce programme ne se sont pas présentées. Il y a eu des critiques parce que nous recrutions des étudiantes parmi les finissantes des écoles supérieures qui auraient pu se diriger vers les écoles d'infirmières. Nous avons comme tactique d'encourager celles qui font preuve d'aptitudes spéciales et qui, d'après notre jugement, possèdent les qualifications requises pour être acceptées dans les écoles d'infirmières professionnelles ou pratiques. Nous en avons eu un groupe, particulièrement parmi les aides noires, qui se sont jointes aux écoles d'infirmières professionnelles.

Sauf l'augmentation des salaires, les chances d'avancement sont plutôt rares; cependant la majorité des aides semble trouver une certaine satisfaction dans les services qu'elles remplissent et n'ont aucun désir de se cultiver davantage, ni d'assumer plus de responsabilités. Par le fait que les conditions d'engagement et de travail sont bonnes, que le statut est officiel, la plupart des membres de cette catégorie a l'impression de rendre de réels services et en est vraiment satisfaite.

Quoique tous les aspects du programme n'ont pas été remplis aussi exactement que nous les avions tracés, ce qui est dû en grande partie au manque de sérieux chez le personnel infirmier en général, nous croyons que le service des aides entraînées et le développement de l'équipe du nursing a contribué à donner des soins meilleurs que nous n'aurions pu le faire sans les aides. Nous croyons également que les infirmières graduées et étudiantes, selon leur expérience dans l'organisation de ce service et

l'emploi de la méthode d'équipe, ont éprouvé une plus grande satisfaction à leur travail parce qu'elles pouvaient atteindre de plus près la perfection dans les soins individuels aux patients. Voici la déclaration du Dr. Brown:

> Personne ne peut prétendre que l'organisation d'un excellent service de nursing, variant selon les diverses exigences du milieu et établit selon les principes de base, soit chose facile ou encore puisse se développer d'une manière uniforme. Nul ne connaît la diversité des conditions d'un hôpital à l'autre et d'une agence à une autre, par conséquent nul ne peut approuver une méthode unique . . . survilement copiée sans tenir compte de son adaptation. L'expérience, l'union et l'échange des idées, la critique des résultats obtenus, suivies d'une expérience encore plus vaste à base d'étude et d'analyse — voilà ce qui est à recommander. De plus, la profession d'infirmière, les organisations sanitaires comprenant les administrateurs de l'hôpital, et les laïques intéressés dans le changement social doivent être convaincus que les nouvelles méthodes du soin des malades doivent évoluer dans une juste proportion en nombre et en qualité.

C'est dans cet esprit d'union et d'échange de vues que nous avons fait connaître nos expériences, espérant qu'elles offriront des suggestions aux personnes intéressées à améliorer le service des malades en employant des aides-infirmières. Nous comprenons très bien l'importance d'étudier davantage cette question afin de fixer un critérium servant de base dans la détermination des relations entre les groupes professionnel et non professionnel et dans les investigations économiques relativement à l'hôpital et au patient. Nous conseillons fortement des études poussées dans tous ces domaines et la publication des résultats obtenus.

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* * *

Liste des activités approuvées pour les aides-infirmières de tous les départements:

Les aides-infirmières doivent remplir leurs fonctions avec ou sous la direction d'une infirmière professionnelle. Cette infirmière est entièrement responsable du soin des patients.

Les activités énumérées ci-après sont celles que les aides-infirmières peuvent accomplir. Tout autre travail qui relève des spécialités doit être écrit et affiché visiblement dans le département afin de renseigner le personnel infirmier du jour, de la soirée, ou de la nuit.

1. Technique du bain à la baignoire.
2. Technique du bain au lit.
3. Installation des malades pour la nuit.
4. Transport des patients en chaise roulante.
5. Transport des patients sur la civière.
6. Manière de donner et d'enlever les bassines.
7. Dosage des urines.
8. Distribution des pots à l'eau.
9. Dosage des excrétas.
10. Température buccale et rectale.
11. Technique des sacs à eau chaude.
12. Technique des sacs à glace.
13. Application des coussins de caoutchouc.
14. Service des plateaux aux patients.
15. Aider les grands malades à s'alimenter.
16. Admission et départ des patients.
17. Préparation des patients pour examen physique.

18. Préparation des patients pour examen pelvien ou rectal.
19. Technique des lavements.
20. Introduction du tube rectal.
21. Technique des lits: fermés, ouverts, d'opérés, et d'urgence.
22. Assister les patients pour examens; recueillir, étiqueter, et enrégistrer les prélèvements.
23. Soins aux patients des chambre d'isolement.
24. Conduire le patient à la salle d'opération dans un case d'urgence, lorsque l'infirmière professionnelle n'est pas disponible (avec permission de l'officière du département à chaque fois).
25. Surveillance du patient à son retour de la salle d'opération; après son réveil seulement et si son état général le permet.
26. Technique du lavage de tête.
27. Application des compresses chaudes ou froides (non stérilisées).
28. Ensevelir les morts.
29. Conduire les patients aux cliniques (ou dispensaires), au bureau de la caissière, etc.
30. Entretien des autoclaves.
31. Entretien des effets personnels du patient.
32. Entretien et préparation des cabarets aux traitements.
33. Entretien et stérilisation des objets.
34. Entretien des armoires aux médicaments (assigner cette tâche aux aides qui sont dignes de confiance).
35. Soin des instruments spéciaux tels que: le sphygmomanomètre, les appareils électriques, les aspirateurs à eau, etc.
36. Soin et arrangement des fleurs.

PROGRAMME DES AIDES INFIRMIERES

Date et Heure	Théorie	Surveillance et Travail Pratique
Première Semaine		*Huit heures de travail par jour* sous la direction d'une infirmière graduée. Ce temps comprend aussi les heures de classes et de surveillance.
1er Jour		
Cours 1—2 hrs.	Orientation.	
Cours 2—2 hrs.	Entretien d'une chambre de malade.	
	Démonstration d'un lit fermé.	*Pratique.*
2e Jour		
Cours 3—2 hrs.	Transport d'un malade sur une chaise roulante ou sur une civière.	Répétition de la démonstration du lit. *Pratique:* transport du patient sur une chaise roulante et civière. *Pratique surveillée:* transport du patient sur une chaise roulante et civière.
3e Jour		
Cours 4—1 hre.	*Dosage* des liquides et des urines. *Démonstration sur la manière de* donner une bassine et de faire le dosage des urines. *Démonstration* sur l'entretien des pots à l'eau.	*Pratique:* mesures et fiches. *Surveillance:* pots à l'eau bassines fiches.
4e Jour		
Cours 5—1 hre.	Préparation des patients pour le repas.	*Surveiller* la préparation des patients et le service des repas dans les salles.

Date et Heure	Théorie	Surveillance et Travail Pratique
5e Jour		
Cours 6—1 hre.	Préparation et installation pour la nuit.	*Pratique surveillée* de l'installation pour la nuit.
Deuxième Semaine		
8e Jour		
Cours 7—2 hrs.	*Démonstration* d'un bain au lit. *Démonstration* d'un lit avec un patient. Entretien journalier d'une chambre.	*Pratique* des bains sous surveillance.
Cours 8—1 hre.	Prévention des plaies de lit. Confort du patient. Usage des appareils.	
Cours 9—1 hre.	Revision.	
9e Jour		
Cours 10—2 hrs.	Température des solutions. Sacs à eau chaude. Sacs à glace.	*Pratique* de la lecture des thermomètres sous surveillance.
10e Jour		
Cours 11—2 hrs.	Lecture des thermomètres cliniques. Température des patients. Entretien du cabaret aux thermomètres.	*Pratique* de la lecture des thermomètres cliniques. Température sous surveillance.
11e Jour		
Cours 12—2 hrs.	Aide à l'admission et au départ des patients. Bain à la baignoire. Préparation des patients pour examen physique, rectal, pelvien.	*Pratique* de la préparation des patients pour examen physique, rectal, pelvien.
12e Jour		
Cours 13—2 hrs.	Divers examens ou tests. *Démonstration* d'un lit d'opéré et d'urgence. Préparation des cabarets à pansements. Surveillance des patients pendant inhalation d'oxygène.	*Pratique* sous surveillance.
Troisième Semaine		
15e Jour		
Cours 14—1 hre.	*Technique des lavements:* évacuant, nutritif, huileux, salin. Introduction du tube rectal.	*Pratique* de la préparation des lavements. Injection rectale sous surveillance.
16e Jour		
Cours 15—1 hre.	Entretien et ménage.	
Cours 16—1 hre.	Entretien des autoclaves.	*Pratique* du nettoyage des autoclaves.
17e Jour		
	Principes d'isolation.	
Cours 17—2 hrs.	Soin des patients isolés.	*Pratique* sous surveillance.

Total: 25-26 hrs.

Cette période de temps peut varier selon le nombre du groupe et leur facilité d'assimilation.

Trends in Nursing

Average reading time — 6 min. 24 sec.

One Nurse's Philosophy

A SHORT newspaper item by a nurse describing the Winnipeg flood makes one realize the essential fineness of people. After explaining that the nurses were on 24-hour call and had spent one night building a dike around the residence she goes on to say "never have I seen so much kindness, so much love, and so much concern shown by a people as at this time of crisis. I cannot help but think that somehow it will make us all realize the fineness of human nature. Even though the sorrow caused will hurt it will make us wise." This lovely thought expressed by a young nurse lets light into some of the dark corners.

Career Pamphlet

The new booklet "What You Want to Know about Nursing" published by the Department of National Health and Welfare has gone over very well. Requests for the book have been so great that the department is completely out of the first edition. We hope the second edition will not be too long coming from the printers.

American Recruitment Program

A new folder on practical and professional nursing entitled "Nursing Offers You a Choice on the Health Team" is now available.

Expanding Programs

Why does the United Nations concern itself with the problems of economic development?

Because the basic purpose of the United Nations is "to promote social progress and better standards of life." The Charter also calls for "conditions of stability and well being which are necessary for peaceful and friendly relations among nations." All members of the United Nations have pledged themselves "to take joint and separate action in cooperation with the organization" for the achievement, *inter alia*, of "higher standards of living, full employment, and conditions of economic and social progress and development."

Arrangements have been made for international teams of experts to advise on economic development programs; the provision of fellowships for the training abroad of experts from under-developed countries; and the promotion of visits of experts to train technicians within under-developed areas and to assist in the organization of short-term training institutes. The secretary-general was also authorized to assist governments in obtaining technical personnel, equipment and supplies, and to arrange for other services including the organization of seminars on special problems of economic development and the exchange of current information on technical problems.

— *United Nations, Department of Public Information, Background Paper No. 60, Lake Success, N.Y.*

The Majority Needs to Know

"There is no single task before us," says Janet Geister, "greater than that of helping the majority of nurses to grasp these truths—the inexorable movements affecting medical and nursing science, etc.—and relate them to the new objectives in nursing education practice and legislation." The majority is defined as the main portion of the total nurses in the country whether or not they are members of our professional associations. "The strong profession is not the one of great numbers, but one whose members are well informed," says an authority. We tend to place more responsibility for decisions on the rank and file but this trend may result in harm unless it is

accompanied by a well thought out campaign of education and information. All nurses are concerned with the problems of good nursing care for patients but the right answer to the many problems cannot come unless the majority participate *in thought and action*. "Being well informed is to *understand the significance* of the issues and trends, and to know what can be and is being done about them." Understanding doesn't come in a flash. Back of it is the impact of a drop by drop rain of ideas and information, which finally comes to have meaning. "First we have the facts, then we reason from those facts, then we make a practical judgment."

Our present methods of helping the nursing profession keep abreast of the times is inadequate. The *Journal* is not enough; statistical reports are not enough. "Nurses should know about our *professional national associations*. The issues and trends before nursing are irrevocably tied up to our means of doing something about them." The purpose of organization is to act for nurses collectively. We need more reports that will interpret the whys and wherefores. "We need more interpretations. Every major issue needs to be broken down into smaller subjects and fully explained in order that the meaning of the whole can be understood. A series of simple, clear and brief releases, each treating an important part of the whole, can be ever so much more effective than a long piece giving us the whole story in one massive dose." We must recognize this need to inform the profession as a whole because the "degree of our progress is definitely related to the degree of information that prevails among nurses."

—Candidly Speaking, *R.N.*, May 1950.

The Team Approach

An article that strikes a new note appeared in *Public Health Nursing*, June 1950, under the title "The Team Approach in a Hospital Consultation Program." The program functions as follows: The maternal and newborn services of a hospital are surveyed jointly by a team composed of obstetric, pediatric and public health nursing consultants. Every phase of the hospital's activities relating to the care of maternal patients and newborn infants is evaluated. Following the survey, the team meets to discuss findings and to make a joint plan of suggestions and recommendations which represent the combined thinking of the members of the survey teams.

There are four major areas in which the public health nursing consultants may be of assistance to the hospital nursing personnel:

1. Evaluation of and strengthening the quality of nursing care given to hospital maternity patients and newborn infants.
2. Evaluation and simplification of nursing techniques as a means of making the most efficient use of available nursing service.
3. Strengthening the program of teaching mothers during the antepartal and postpartal periods.
4. Strengthening the liaison between the hospital and the community public health nursing agencies to promote continuity of care of patients between the hospital and the home.

Orientation et Tendances en Nursing

La Philosophie d'une Infirmière

Une infirmière décrit dans un journal l'inondation de Winnipeg et ne peut s'empêcher de s'exclamer, "Comme il y a de braves gens!"

Elle explique que les infirmières étaient en service 24 heures par jour, qu'elles ont passé

une nuit entière à maintenir un barrage autour de la résidence des infirmières. "Jamais," dit-elle, "je n'ai vu autant de charité, de bonté, et d'intérêt montrés par la population envers les uns les autres. Cette épreuve nous fera réalisé qu'au coeur de tout homme Dieu a déposé un peu de sa bonté. Si cette épreuve nous a causé bien des souffrances, elle nous a aussi donné confiance dans la nature humaine." Cette réflexion d'une jéune infirmière fait du bien et donne confiance.

Nos Vieillards

Lors de leur assemblée du printemps, les infirmières de l'Alberta discutèrent l'un des problèmes qui demande, à l'heure actuelle, le plus de considération — celui des personnes âgées.

Grâce à une meilleure hygiène et à de meilleurs soins médicaux, la durée de la vie a été prolongée. Notre société compte un nombre de plus en plus grand de personnes âgées, qui demandent souvent des soins, soit à la maison, soit à l'hôpital.

Comment pouvons-nous leur aider? Comment prévenir les maladies du vieil âge? Comment mettre à leur disposition les ressources de la physiothérapie, de l'occupation thérapeutique? Combattre l'isolement par des récréations convenant à leur âge et à leur santé? La psychologie du vieillard malade? Toutes ces questions ont été étudiées. Ce problème est à l'ordre du jour.

Clarté sur la Profession d'Infirmière

Ce livret, préparé par le Ministère National de la Santé et du Bien-Etre, a été bien accueilli. Les demandes ont été nombreuses et la première édition anglaise est épuisée. Nous espérons qu'une deuxième sera prochainement mise à notre disposition.

Le Recrutement aux Etats-Unis

Un nouveau dépliant sur la carrière de l'infirmière et de l'aide-malade, portant le titre "Nursing Offers You a Choice on the Health Team," est maintenant offert.

Les Nations Unies et le Développement Economique

Pourquoi les nations unies s'intéressent-elles tant au développement économique? Parce que le but de cette société est "de promouvoir les progrès sociaux et le niveau de vie." Elle considère aussi que "des conditions de stabilité et de bien-être sont nécessaires si l'on veut que des rapports pacifiques et amicaux existent entre les peuples."

Dans les pays où le développement économique est en retard, l'on travaille à favoriser ce développement en y envoyant des équipes d'experts chargés de former des techniciens. L'on a offert des bourses d'études à l'étranger; l'on a organisé des journées d'étude, etc., afin d'aider ces pays.

Les Infirmières Doivent Etre au Courant

La deuxième grande guerre a amené des changements considérables dans les données de la médecine moderne. La même guerre a amené des changements non moins considérables dans l'économie de la société.

Tous ces facteurs ont une influence sur le nursing, qui ne peut plus marcher sur les traditions du passé. Il faut donc que les infirmières soient renseignées sur ce qui peut influencer les destinées de leur profession.

Une association puissante n'est pas toujours celle qui compte un grand nombre de membres, mais celle dont les membres sont le mieux renseignés. Il n'est pas facile de comprendre tous les changements qui peuvent se produire et comment ils nous affecteront — il faut s'arrêter et réfléchir profondément.

Il est mieux d'étudier une question à la fois que d'embrasser tous les problèmes. Renseignons les infirmières et que ces dernières soient avides d'information.

L'Equipe en Nursing dans L'Hygiène Publique

L'infirmière hygiéniste, à titre de consultante, a sa place dans l'équipe du personnel hospitalier. Son rôle est tout indiqué en obstétrique et en pédiatrie.

L'infirmière hygiéniste, a t'on trouvé, à la suite d'une étude faite sur le sujet, peut rendre service à titre de consultante: (1) Evaluer et augmenter la qualité des soins donnés aux malades à l'hôpital, en maternité, et chez les nourrissons. (2) Evaluer et simplifier la technique, afin d'obtenir un meilleur rendement de la part du personnel infirmier. (3) Dans les consultations pré- et post-natales, un enseignement plus intensif peut être fait aux mères. (4) Des relations plus étroites peuvent être établies entre l'hôpital et les organisations d'hygiène publique, et entre l'hôpital, le malade et sa famille.

The spider, arch-enemy of the fly and a highly skilled weaver, has but one lens in each eye.

Lyle Creelman *Writes . . .*

Average reading time — 4 min.

ONE MOONLIGHT Saturday night in December, Dr. Dorothy Taylor, from the Ministry of Health in England, and I found ourselves winging our way over the high Alps in a large Swiss Air Constellation on a non-stop flight to Cairo. The sun rose just in time for us to catch a glimpse of ships on the blue Mediterranean below, the port of Alexandria to our right, the desert and the Nile, and then we were landing at the new King Farouk Airport about 15 miles outside Cairo. It seemed to be in the heart of the desert and, as we drove along to the city, we saw little but sand, with Arab tents and camels at intervals. I think my memory of the approach to Cairo will always be associated with the huge scarlet poinsettias which were seen in many gardens. Their brillance was a startling, an unexpected contrast to the rather drab native costumes worn by the men, the black garb of the peasant women, the poorly clad children everywhere, the long-suffering donkeys, and the monotonous honking of automobile horns.

It was necessary for us to travel to Alexandria to our regional office headquarters that same afternoon. After a hurried breakfast at Shephard's, we selected a *dragoman* (guide), who had been one of the least insistent of those standing in front of the hotel awaiting the uninitiated tourist, and set out to see something of Cairo. Our dragoman was Abdel-Fattah A. El Shaer. I wish I could describe his colorful costume. It also is a show for the tourist. No doubt when he has completed his day's work he puts on the simple native cotton tunic or, if he has been long enough in the game, he probably can afford British tweeds. With them he will wear the red fez, now almost a symbol of the extreme nationalist spirit.

Typical home of the Egyptian fellaheen.

It is interesting that nearly every dragoman professes to be an archeologist. He is willing to arrange any kind of tour to any part of Egypt. To Luxor—where he will take you to the Valley of the Kings and the ruins of the once beautiful temples. To Aswan—where the ancient Egyptians excavated by hand the famous granite and where in modern times a great dam has been constructed across the Nile. He will arrange a camping trip by camel caravan to the desert or a visit to an oasis.

Our time was limited. We had to content ourselves with a visit to the famous Mohamed Ali Mosque from which we saw the city of Cairo with its minarets and teeming streets below. In the distance were the great Pyramids and behind us the hills from which the tens of thousands of slaves dug the stone, carried it across the Nile and the desert, and erected those great monuments.

Our train to Alexandria took us through the very fertile area of the Lower Nile, where there live 2,000 people to every square mile and where the land produces three crops yearly. (In contrast Canada averages three people to the square mile.) The *fellah* (peasant) and his family, the camel, the donkey, the bullock, all moving along the palm-lined roads, the mud brick houses of the villages with the twigs and grass drying on the rooftops, were familiar sights by the time

we reached our destination, the port once such a familiar anchorage for the ships of the British Navy.

Since Friday, and not Sunday, is the religious holiday in Moslem countries we reported to the office immediately and were received by Sir Aly Shousha, Pasha, director of the Eastern Mediterranean Region. I should tell you that the purpose of our trip was to meet a request made some time previously by the Egyptian Government to WHO for an evaluation survey of their maternal and child health services. As nursing is an essential part of a health program for mothers and children it was decided that a nurse from WHO Headquarters might assist Dr. Taylor in this project. After an orientation in the headquarters we had a brief glimpse of the health program in Alexandria. It is interesting that this city is the only municipality in Egypt with its own health administration. The whole of the remainder of the country, which is slightly larger than the province of Ontario, and has a population of 19,000,000, is administered from the government offices in Cairo.

In a country where language and customs are strange, where even the written letters and numbers convey nothing to one unfamiliar with the symbols, and where the gracious hospitality of the people makes it essential to take time for the drinking of innumerable cups of Egyptian coffee, in spite of every facility put at our disposal it was not easy for us to obtain an adequate background of information on which we were expected to be so bold as to make an "evaluation" of certain of the health services. I am sure you will want to hear something of nursing in this country where only a short time ago women wore the veil.

In Memoriam

Elma Ruth Coon, who graduated from the Ottawa Civic Hospital in 1931, died in Montreal on May 22, 1950, following a lengthy illness. She had served on the staff at the O.C.H. until 1940 when she enlisted with the group of Canadian nurses who helped staff military hospitals in South Africa. Returning to Canada in 1942, Miss Coon served on the Canadian Army hospital ship *Letitia* during the duration of World War II. Following the war she worked in Peterborough and Kingston and was on the Staff of Queen Mary Veterans' Hospital, Montreal, prior to her illness.

* * *

Jean Corbishley, a graduate of St. Michael's Hospital, Toronto, in 1910, died recently. Most of her professional life was spent in private nursing in Montreal and in the United States.

* * *

Jean Bernice (Myles) Jamieson, a graduate of the General and Marine Hospital, Collingwood, Ont., died on May 18, 1950, in Toronto. Mrs. Jamieson took her public health nursing certificate at the University of Toronto School of Nursing and was on the staff of the Victorian Order of Nurses in Timmins prior to her marriage.

* * *

Catherine Vera Jones, a graduate of the Royal Victoria Hospital, Montreal, died in Ralston, N.J., on May 25, 1950.

* * *

Katherine W. (Ryan) Lang, who graduated from St. Michael's Hospital, Toronto, in 1910, died recently in Kitchener, Ont.

* * *

Betty (McRobbie) McConnell, who graduated from the Royal Victoria Hospital, Montreal, in 1936, died in Ottawa in May, 1950.

* * *

Jessie M. Mortimer, a 1902 graduate of Victoria Hospital, London, and formerly a supervisor of the medical wards there, died on May 14, 1950. Miss Mortimer had operated the Nurses' Registry in London for many years until ill health caused her to retire 10 years ago.

Student Nurses

Learning by Seeing

RUTH B. BROWN *and* SHIRLEY E. GIBSON

Average reading time — 3 min. 12 sec.

AFTER A BRIEF but pleasant trip by bus to Acton, we made our way to the office of the Baxter Laboratories of Canada Ltd. We were heartily greeted and briefed on our tour.

The first stop was the laboratory of the plant. A member of the technical staff explained in detail about the manufacture of parenteral fluids. All ingredients used in the making of intravenous solutions are tested prior to use. The already near-pure water is distilled by means of a compressor still.

In the mixing-room the solutions are filtered through charcoal from large glass-lined vats into stainless steel pipes leading into the filling-room. While in the vats a sample of each solution is taken and the proper percentage of its ingredients regulated.

Prior to filling with solution the containers are washed, given a soft-water rinse, and checked for flaws. The containers are fitted into pockets in a specially constructed washing-machine which contains a solution of washing soda and are washed six times with hard water and twice with demineralized water before re-checking for flaws.

The employees in the filling-room are dressed in plastic coats, caps, and rubber gloves and here the airways and corks are prepared by washing and inspecting. A machine fills the container with the required quantity of solution, a stopper and glass airway are inserted into the opening. These stoppers have previously been treated with a special type of enamel to prevent chipping of the rubber. Each opening is covered with an inner rubber disc and an outer metal disc on which the name of the solution is marked. These are put on by a machine which, at the same time, creates a vacuum. All parts are secured in place by a close fitting outer ring.

The containers are then placed on skids and autoclaved at 232°F. under 15 pounds pressure for 30 minutes. When taken out of the autoclave a plastic indicator is checked to determine the sterility of the load. They are then left to cool for 24 hours.

The next day each container is held under a light in front of both a black and white ground to inspect for foreign particles. If any particles are found the solution is discarded. After inspection, the containers are given a hot-water rinse to ensure a clean appearance, labels are applied, and a metal band and handle adjusted. The finished product is placed in cartons and sent to the warehouse from where it may be shipped to any location in Canada.

Following our trip through the plant we visited the rabbit room where 60 rabbits were caged, starved, and ready for injection with specimens of solution. The test taken here is for pyrogen reaction. The rabbit's temperature is recorded prior to injection and at two-hour intervals thereafter. If the rabbit develops an elevation of temperature the whole batch of solution from which the specimen is taken is discarded.

One container from each autoclave load is also tested on aerobic and anaerobic mediae. These mediae are tested periodically to judge their

Misses Brown and Gibson are student nurses at the General Hospital, Galt, Ont.

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Ottawa, Ont.

capability of producing bacterial growths.

After this most interesting and informative tour of the plant we were shown slides of instruments and equipment used in the past to administer intravenous solutions. In the light of modern methods such equipment appeared crude and amusing.

Following the tour of the plant we were entertained by several games of alley bowling, a tasty lunch, and concluded our trip by a sing-song on the bus on the way home.

Book Reviews

The Nursery Age—A Textbook for Nursery Nurses and Mothers of Young Children, by Helen M. Cousens. 280 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1949. Illustrated. Price $2.50.
Reviewed by Mary Blackwood, Supervisor, Hamilton General Hospital, Ont.

This book presents an instructive outline on the care of young children, particularly the preschool age group. It reviews the care during infancy and points out the factors influencing growth and development. Chapters are devoted to the feeding of children, environment, physical activity, the care of the nursery, infectious diseases of childhood, and the public health services. The Young Child in the Home and The Young Child in the Nursery present different phases of the care of normal children. The book is well arranged —chapters are subdivided with clear-cut headings and illustrations and helpful summaries.

There are minor points which indicate the difference in the British point of view. There are indications of Britain's post-war difficulties —e.g.: "Government concentrated orange juice should be diluted with not less than eight times the quantity of water and sugar added to taste . . . Rose-hip syrup, tomato juice, black currant juice, or turnip juice may be given."

Graduate nurses could use this book as reference in teaching nurses regarding the normal child. It would be helpful in home

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nursing classes or for teen-age girl groups.

The book does not actually offer too much help for "The Nursery Age." Workers in our day nurseries would understand their charges better if they had a thorough knowledge of the background of children as presented by Miss Cousens. In view of the increasing popularity of nursery schools in this country and the shortage of trained personnel to staff such institutions this book might be used as a reference because the writer has had vast experience in a country where nursery schools have been established for many years.

Communicable Diseases and Their Nursing Care, by Evelyn Pearce, S.R.N. 392 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 1949. Price $3.25.

Reviewed by Dorothy McKeown, Instructor of Nurses in Pediatric Nursing and Communicable Diseases, Halifax Infirmary, N.S.

In her prefatory explanation Miss Pearce states that she decided to replace her original book on "Fever and Fever Nursing" by this larger and more comprehensive one in order to meet the changes in hospital services and in the training of nurses that will no doubt take place with the passage of the Nurses Bill in England. This textbook reflects the experience of many years of teaching and study. Consequently, the volume is founded on a comprehensive knowledge of the old and new literature on communicable diseases.

Chapter I contains an introduction to microbiology and the author makes use of the new nomenclature for pathogenic organisms. Such topics as "hygiene of the mouth," "defences of the body," "methods of isolation," "air travel regulations," and "care of a communicable disease in a home" are typical of the varied matters of interest in communicable diseases that are given attention. The nurse's role as a teacher is stressed throughout.

Miss Pearce states: "The nurse forms a liaison between the general public and the medical and health authorities." The health of the staff of a hospital as an important

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factor in the control of communicable diseases is emphasized.

The outstanding feature of this volume is the author's ability to give importance to the more commonplace although necessary details of nursing care—an aspect of communicable diseases so often overlooked in similar textbooks on this subject. In a simple and straightforward style she makes the reader realize the importance of good hygiene of the mouth, diet, rest and sleep. Mention is made of the complications resulting from neglect of these factors.

The final chapter is devoted to questions used in state examinations and should be of value to the instructor. This is an excellent book for the use of both the student and graduate nurse.

Illustrated Handbook of Simple Nursing. Compiled and illustrated by Wava McCullough, assisted by Marjorie Moffit, R.N. 238 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Price $3.50.

Reviewed by Winifred Barratt, Registrar for Licensed Practical Nurses, Manitoba Department of Health and Public Welfare.

Wava McCullough assisted in making a job analysis of the work of the practical nurse for the Vocational Division, U.S. Office of Education. She states that "the need for illustrated work sheets at that time projected the idea for this book." Consequently there is a profusion of illustrations. The chief character is a whimsical nurse caring for the patient's environment, comfort, and hygiene; performing certain therapeutic, special, and aseptic procedures; also amusing and feeding the convalescent patient.

The cartoon-style illustrations are concise, clear, and attractive and the nurse portrays good body mechanics. The type used for the written content is hand-printing.

Unfortunately, some of the content is inconsistent. For instance, in care of rubber tubing — "If rubber tubing has not been used for several weeks, boil it for 15 minutes." Why? Again, in Care of Instruments— "Knives and scalpels must not be boiled more than 1 minute." Teachers and students in nursing assistant courses will enjoy studying the pictures in this book.

Orthopedic Nursing, by Robert V. Funsten, M.D., and Carmelita Calderwood, R.N. A.B. 660 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents:

McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1949. Illustrated. Price $5.00.

Reviewed by Sister Anne of the Sacred Heart, Pediatric Supervisor, St. Paul's Hospital, Vancouver.

The aim of the authors was to collect into one volume the background of medical and nursing techniques necessary to help the nurse in caring for the orthopedic patient, stressing clearly established principles of knowledge and procedures. Perhaps in the past the importance o' good orthopedic nursing has not been sufficiently stressed in books on orthopedic conditions. In this newly revised edition, which has been brought in line with newer developments, due emphasis is given to this particular phase of nursing.

The text, which is divided into units, is well organized and presented with clarity and contains illustrations which in themselves are of invaluable assistance to the student nurse as well as the graduate.

Unit One is directed toward the needs of the patient as an individual and should help to stimulate the nurse to look beyond the needs of the present situation and to increase her own background of knowledge. It should also cultivate a sympathetic understanding, together with a kind and intelligent attitude toward the patient.

The second unit, dealing with the nursing care of pre- and post-operative patients, patients with casts, and the care of casts themselves, is a most valuable contribution. Throughout the other units orthopedic diseases and conditions are well defined and the nursing care which is so necessary for this type of patient is well emphasized.

The authors are to be highly congratulated on the time and effort they have put into a work so comprehensive in its medical information and nursing techniques, yet so simple and practical in its contents. A book such as this will help the nurse to realize the important role she does play when she knows how to give nursing care to the orthopedic patient.

Essentials of Public Health, by William P. Shepard, B.S., M.D. and collaborators. 600 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1948. Illustrated. Price $6.00.

Reviewed by Blanche Emerson, Acting Director of Public Health Nursing, Alberta Department of Public Health.

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physician and private practitioner, medical students, and members of allied professions, the object being to prepare them to fill their role of leadership in community health matters.

The authors point out that they are not trying to make all doctors health officers but that public health is a recognized specialty of medicine; that the practising physician should be familiar with special problems and techniques of public health, in the same manner as he has a working knowledge of other specialties. They are convinced that every physician practises preventive medicine to some degree and that he should be able to give sound advice on community health problems; that too often the physician has trailed where he should have led. Many public health activities have come into being because of public demand and, if public health is to be successful, there must be a widespread application of preventive measures that comprise a public health program that can only come about by organized community effort. The writers feel that the physician should be so well informed on this subject that he is able to give sound leadership. They point out that there is no final answer in the spread of disease from one human being to another and that the future of public health is one of research and education. A stable and decent civilization depends to a large extent on the trained physician and public health officer.

This is an excellent handbook, dealing as it does with all phases of public health in an up-to-the-minute manner.

While primarily written for the benefit of American physicians and public health personnel, it should be required reading for all public health workers everywhere.

Use Our Full Address

We are quite prepared to agree that *The Canadian Nurse* is a very familiar periodical to many other persons besides nurses. However, the post office authorities are sometimes baffled by the way our correspondents address letters to us. Very, very frequently we receive mail without our street address being noted. Please put our **full address** on every time to avoid possible loss of mail and certain delay. We admit it is in rather insignificant type at the bottom of the Table of Contents page but it is there.

A Recruitment Idea

(*concluded from Page 648*)

pamphlets, year books, etc., from numerous schools throughout Canada was included. Many of the guests spent a good deal of time here, browsing through the literature and comparing notes. A special display indicated the opportunities provided in university schools.

Emphasizing the fact that nursing students can and do lead a normal life was a large display on activities. This included sport trophies, schedules, equipment, glee club announcements, novel dance programs, the school monthly paper *Pinky* and year book *The Chevrons*. Large posters in the school colors of blue and gold called attention to the attributes of a good nurse and added to the festive appearance of the demonstration room. School crests were also used to advantage. The table was centred by two dolls, dressed in exact replicas of the uniforms of preliminary and senior students. Students who received, poured tea, and served their guests demonstrated another aspect of student life—the development of social graces.

A Modern Prometheus

According to ancient legend Prometheus brought fire to the earth. That was fine—at the time. But bringing fire to the earth is no longer necessary. Vacationists and campers who burn up grasses and forests are no friends of man or of nature. Summer is a particularly dangerous time. A dry spell and brush burns like fury. Summer cottages and hotels are often fire hazards. And campers, who take the utmost precautions at home, forget all about fire risks on a holiday.

Information Wanted

The whereabouts of **Maria Groger or Groeger** is being sought by the Canadian Red Cross Society at the request of her sister, Elfriede. She was known to have lived in Montreal at one time but efforts by the Nursing Registry and the A.N.P.Q. to trace her have drawn a blank. Anyone having any information about her is requested to write to *Miss Lavina Johnson, Director, National Enquiry Bureau, Canadian Red Cross, 95 Wellesley St. E., Toronto 5, Ont.*

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To take place on **October 18, 19 and 20, 1950,** at **Halifax, Yarmouth, Amherst, Sydney,** and **New Glasgow.** Requests for application forms should be made at once, and forms MUST BE returned to the Registrar by **September 19, 1950,** together with: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Diploma of School of Nursing; (4) Fee of $10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations, and is within six weeks of completion of the course of Nursing.

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The Registered Nurses' Association of Nova Scotia
301 Barrington St., Halifax, N.S.

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The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments—Calgary: *Grace Pettifor* (University of Alberta School of Nursing and U. of A.). Halifax: *Isobel Paterson* (Royal Victoria Hosp., Montreal, and Dalhousie University). London: *Dora Pearce* (Victoria Hosp., London). Moncton: *Helen Lafitte* (Hotel-Dieu, Moncton). Ottawa: *Elsie Cribb* (Charing Cross Hosp., London, Eng.). Sarnia: *Debby Hooper* (Gen. Hosp., Chatham, Ont.). Toronto: *Betty Foster* (Victoria Hosp., London). Victoria: *Joyce Wylie* (Royal Jubilee Hosp., Victoria).

Resignations—Hamilton, Ont.: *Marion Hunter* and *Frances Riddell.* London: *Dorothy Thompson.* Montreal: *Jacqueline Reid* and *Mrs. B. Smith.* Toronto: *Joyce Bagshaw.* Victoria: *Barbara Munro.* Windsor, Ont.: *Marian Cowdrey.* Winnipeg: *Vivian Pearce* and *Suzanne Petursson.* Wolfville, N.S.: *Jean Adams* as nurse-in-charge.

Causes of Obesity

The most common cause of obesity is overeating. In many instances overeating may be due to a psychic disturbance in which the individual is unprepared to meet the social demands of everyday life. There is also a group of people who lack normal interests in life and obtain pleasure in overeating. It is often impossible to appease their appetites because they are unable to satiate their sensory desires. Another form of mental conflict considered important in females is that obesity can be an escape from competition for masculine attention. In this condition overeating is an excuse.

—DR. LOUIS PALMER

Pellagra

Though pellagra is not the explanation of anything like all the complaints of neurotics and psychoneurotics, it should be kept in mind as a likely cause of irritability and fatigability, loss of energy and weakness, mental depression, and the lack of zest of living.

The treatment of pellagra is simple and reasonably effective for both the severe and mild forms. The diet must be well balanced, of high caloric value, and consist of foods containing the water-soluble, heat-soluble (P-P) pellagra-preventing vitamin G whenever pellagra is suspected. Especially recommended for their vitamin G value are: sweet and buttermilk; fresh and canned beef; chicken; canned salmon; smoked lean pork; rabbit; fresh or canned collards and kale; and green peas.

There seems to be considerable variation in the individual vitamin requirements. In certain conditions, such as hyperthyroidism, pregnancy, and illnesses that may require dietary restrictions, the utilization of vitamins may be either increased or the food intake decreased, so that a vitamin deficiency may result. In all such instances, the vitamin intake must be supplemented.

The generally accepted therapeutic agents are dried yeast powder, liver extract, and nicotinic acid. Seventy-five to 100 grams of yeast daily, recommended by many, has the disadvantage of inducing vomiting and diarrhea in some cases and is very objectionable to the taste of a great number. It is best given in tomato juice. Seventy-five to 100 grams of liver extract orally is also recommended. An equivalent amount of liver in the form of liver extract may also be given parenterally. In severe cases, obviously, large amounts of either or both yeast and liver extract will be required to supply sufficient vitamin G to be effective. For economic reasons as well as therapeutic, synthetic nicotinic acid is preferable.

The dosage of nicotinic acid required has varied from 50 to 100 mg. daily in mild cases, to 150 mg. in the well advanced; and in one case 500 mg. was given daily over a considerable period. It is advisable to supplement the nicotinic acid with dried yeast powder or liver extract or both. Patients should be watched carefully for any untoward effects of treatment.

—Dr. Ernest L. Copley

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Superintendent of Nurses,
Mountain Sanatorium,
Hamilton, Ontario.

News Notes

ALBERTA

EDMONTON

The last meeting of the Instructors' Group, sub-committee of the Educational Policy Committee, A.A.R.N., for the 1949-50 season was held in May at the Misericordia Hospital. E. Mackie, retiring chairman of the classroom group, and M. Delamater, past president of the clinical group, thanked the members for their cooperation and interest during the past year. A welcome was extended to the new executive—E. Bietsch, chairman of combined group meetings; Miss Krukowski, chairman, classroom instructors, and N. Lambert, secretary; Mrs. Harris, chairman, clinical instructors, and V. Protti, secretary.

A summary of activities during the season was presented by both groups. Highlights of the program for the clinical instructors were two group study projects covering "A Plan of Instruction and Administration for the Clinical Instructor" and "The Relationship between the Head Nurse and Clinical Instructor." Mrs. Stewart of the Royal Alexandra Hospital spoke on the possibilities of having clinical instructors cover the 24-hour period in the hospital. A valuable talk was presented by Mrs. W. T. Murray on a workable rotation plan for student nurses. The enthusiasm and willingness of all the members of the clinical group was adequate evidence of the worth of these group discussions and much credit goes to Miss Delamater for her splendid leadership.

The classroom instructors studied three topics, including: The Block System, Qualifying Examinations, and The Value of Audio-Visual Aids in the School of Nursing. As a result of the latter study, a film pool is being formed in order to supply the Alberta schools of nursing with films most suitable for use.

A brief but timely talk was given by Miss Mackie, retiring chairman, regarding the true objectives of group work, emphasizing the importance of each individual being regarded as capable of giving her full share of knowledge and talents to the group.

LAMONT

The 1950 graduation class of the Public Hospital School of Nursing was entertained at luncheon in the Wapiti Inn, Elk Island National Park, by the alumnae association. The 15 members of the class were each presented with a subscription to *The Canadian Nurse*. Rev. Mr. and Mrs. J. E. Kirk of Lamont United Church and Rev. Mr. and Mrs. R. E. Vipond of Metropolitan United Church, Edmonton, were also guests of honor. The Rev. Vipond was guest speaker and was thanked on behalf of those present by Dr. L. Davey of the hospital staff.

Altogether 80 guests were in attendance, including members of the medical, dental, and nursing faculties and graduates.

LETHBRIDGE

The June meeting of District 8, A.A.R.N., was held at the Civic Centre with an attendance of 50, including four from Magrath and three from Crows Nest Pass Hospital staff—90 miles to the west.

Dr. H. A. Arnold gave a very interesting talk on "The Use of Cortisone in the Treatment of Rheumatic Fever." Mr. Brian Henson, who was recently treated with this new drug, was also present.

BRITISH COLUMBIA

LADYSMITH

Official recognition has been given to the newly formed Cowichan-Newcastle Chapter on Vancouver Island. The three towns of Duncan, Chemainus, and Ladysmith now form one chapter and to date have held two successful meetings. Besides the activities of this professional group, the nurses meet as a social club in each town and retain their associate fees to assist in defraying expenses when it is their turn to take the chapter meeting. An average of 50 nurses have attended the meetings. On June 19 the Chemainus nurses were hostesses. Elizabeth Stewart, the president, was in the chair. Mrs. Christine Macleod, supervisor of the observation ward, Royal Jubilee Hospital, Victoria, with Lorna Rutherford, a recent graduate with post-graduate training in psychiatry, were the guest speakers. They outlined some of the advances in the psychiatric field and interested the group in the preventive aspects. Reports of continued interest and activities were given by Mrs. Halmie, Chemainus; Ethel Fairbanks, Duncan; and Mrs. Ted Brown of Ladysmith. The fall meeting will be conducted by the Duncan nurses.

VICTORIA

Royal Jubilee Hospital

The Harmonizer, monthly publication of the hospital Employees' Association, appeared in May as a special historical issue to mark the 60th anniversary of incorporation of the present hospital. Search of early records, review by senior staff members of developments within their own departments, and recollections of old-time employees combine to make an interesting symposium.

Of special interest to graduates of the school is an interview with Mrs. W. H. Bullock-Webster who, as Marie F. DeBou, was a member of the first graduation class in 1892. Isa (Rankin) Dowler, of the 1908 class, also shares her memories of early days. Jessie F. MacKenzie, director of nursing from 1914 to 1927, recalls the opening of the maternity ward in the Pemberton Chapel in 1916. A comparison of "then" and "now" from a patient's point of view comes from a patient 54 years ago who, conveniently for the editors, was recently readmitted. Nurses today are much younger than those she used to have, she comments.

Staff members of 30 years standing include Beryl Ferguson, records librarian, and W.

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Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

Duncan, chief orderly. Ethel Newman, with 26 years to her credit, ranks as pioneer member of the nursing staff.

ONTARIO

District 4

St. Catharines

The latter part of May the alumnae association of the Mack Training School entertained the graduating class at a dinner dance at Welland House.

The June meeting took the form of a picnic supper at the General Hospital cottage for nurses on the lake front at Port Dalhousie. After an enjoyable supper in front of the glowing fire-place, the business meeting followed, several members giving reports of the annual meeting of the Registered Nurses' Association of Ontario.

The annual meeting will be held the first Wednesday of September at 8:00 p.m. in the Leonard Nurses Home, Queenston St.

District 5

Toronto

St. Michael's Hospital

At a recent alumnae meeting D. Murphy reported that there were 693 alumae members for 1950, 49 out of 67 graduates of 1949 joining as members. It was voted to send the president, L. Huck, as representative at the C.N.A. convention in Vancouver. The guest speaker was Dr. William Magner who gave an educational lecture on "The Rh Factor."

Last November, an official visit was made to the hospital by Their Excellencies, the Governor General and Lady Alexander, when the Sisters, doctors, and nurses were presented. Lillian Wohler, of the 1950 class, and Student Body president, presented Lady Alexander with a nosegay.

Twenty-four members of a class of 41 of 1928-31 attended a reunion held in March at the hospital.

Sr. M. Frances has been transferred to St. Joseph's Hospital to assume charge of the dietary department. M. Simpson-Ray, on leave of absence from St. Michael's, is in Scotland visiting many of the hospitals there. P. Upshaw is on the staff of St. Anne's Hospital, Ste. Anne de Bellevue, Que. M. Snell is in the employ of the U.S. Steamship Lines and when last heard from was in Australia. E. Decker is acting superintendent at the Barrie Memorial Hospital, Ormstown, Que. B. Fougere is at St. Claire's Hospital, New York City. C. Watson has been transferred to the Churchill Military Hospital, Fort Churchill, Man. E. V. Baldwin is at the Missouri-Pacific Hospital, St. Louis. M. Shierson is doing general duty at the Galt Hospital. C. Coulombe is nursing in Sturgeon Falls, Ont. K. McCully has returned to nursing in Toronto. M. Schwanbeck, who has been in Saskatoon, is now back in the city. A. Romano has returned to the field of private duty.

Srs. Loretto and Florian and D. Murphy

attended a refresher course on maternal hygiene held at the University of Toronto School of Nursing. F. Hinds is industrial nurse with the Canadian Comstock Co., St. Catharines. M. McGarry is on the staff of the Department of Health, Antigonish, N.S. T. Hayes is with the Department of National Health and Welfare, Ottawa. B. Carr is with the V.O.N. in Ottawa.

Women's College Hospital

The annual picnic at Centre Island concluded a very successful and active six months. The dinner dance in honor of the 1950 graduating class was a gala affair with about 100 of the members present to welcome the 18 new members.

A very special function, a Fireside Tea, was held in honor of Miss R. Duff, who retired after 28 years as hospital dietitian. The alumnae association presented Miss Duff with a leather hand-bag and bill-fold.

The annual Blossom-Time Tea was a very successful and enjoyable function when many of the graduates came from out of town to renew friendships and meet new members. The proceeds went towards nurse education.

District 10

Fort William

Local members of District 10 entertained at a dance in June in honor of the 1950 graduating classes of the Port Arthur General, St. Joseph's and McKellar hospitals. There were around 400 guests. Dr. B. C. Hardiman acted as master of ceremonies for the evening. The guests were received by: Mrs. E. Easton, president; K. Feisel, director of nurses at McKellar; Alice B. Hunter, superintendent of Port Arthur General; and O. Thomas, assistant director of nurses at St. Joseph's Hospital.

In charge of arrangements was A. Malmborg, assisted by Mrs. M. Pittman, M. Waters, and Mrs. Geddes. The Grand March was led by Mr. and Mrs. Geddes. D. Colquhoun, director of nurses at Port Arthur General Hospital, welcomed the graduating classes to the R.N.A.O.

QUEBEC

Montreal

Children's Memorial Hospital

Recent staff appointments include: Eva Bennett, Ellen McGlynn, Marion McKenny, Gladys McLean, Joan Tallon, Shirley Wilson. Phyllis Abbott, Dorothy Caldwell, and Alice Uyede have resigned to be married. Other resignations are G. Blaney, G. Law, and C. Martin.

Royal Victoria Hospital

The Staff Organization is made up of 60 members on the hospital staff and 21 general duty nurses. Committees were formed to look after the overseas parcels, educational programs, and social evenings. Quarterly fees are collected from the members and this

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What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes — as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

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Ottawa.

Every year more Canadian hospitals are using the two excellent textbooks listed below. Both contain the latest advances in nursing and both are arranged for the greatest convenience of instructors and students.

MEDICAL NURSING

By Edgar Hull and Cecilia M. Perrodin. Covers every phase of medical nursing. 844 pages, 172 illustrations, fourth edition, 1949. $4.75.

SURGICAL NURSING

By Robert K. Felter, Frances West, and Lydia M. Zetzsche. This new, radically revised edition contains new units in Orthopedics, and Surgery of the Eye, Ear, Nose and Throat. 308 illustrations, 710 pages, fifth edition, 1950. $4.75.

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money is used for sending parcels to the older nurses in England, flowers for the sick members on the staff—doctors and nurses—as well as bereaved members.

Monthly meetings are held in the nurses' residence and are presided over by the chairman, elected by the members. During the past year, guest speakers included Dr. J. S. L. Browne, who gave an interesting talk on "Acth," Mr. Clarke, personnel manager, who spoke on "Hospital Policy," and Dr. Tweedie on "Prenatal Care." A film on the treatment with antabuse of alcoholic patients was shown.

An informal dance was held in March. In May a bridge and canasta party was held to raise money in aid of the Winnipeg flood and Rimouski fire relief funds which turned out to be very successful financially.

Mrs. G. W. (Gardner) Wells, Islington, Ont., and Henrietta LeVesconte (1898) of Vancouver were visitors at the hospital in June. A very refreshing and most enjoyable two or three hours were spent listening to some of Miss LeVesconte's interesting experiences and reminiscences.

Eleanor Ball is on the General Hospital staff at Kitchener, Ont., as medical and surgical clinical supervisor. Jean MacCallum has left Ward B to take a public health course in September at the University of Toronto.

Joyce Goodman writes, "Miss Peever and I are just beginning the work which accompanies treaty time and, as it is our first experience of Indian Treaty Parties, we are looking forward to it. Almost the whole band comes in and tents dot the reserve. By now, the ice is all gone and we have been enjoying trips in our boat."

Sherbrooke

The annual graduation exercises of Sherbrooke Hospital were held recently at Plymouth United Church with Rev. R. C. Tait giving the invocation, Mr. J. G. Armitage the address of welcome, and the Florence Nightingale Pledge was recited by Vera Graham, superintendent of nurses, and the graduating class. Addresses were also given by Dr. Klinck, who is a member of the nursing committee, and by Margaret Kerr, editor of *The Canadian Nurse*. Mr. Armitage, president of the Board of Governors, presented the diplomas and pins to 13 graduates, prize winners being Patricia Armstrong, Hope Gill, Iris MacLeod, and Dorothy Olson.

The alumnae association held their annual dinner and dance in honor of the 1950 graduating class at the New Sherbrooke Hotel. Helen Woodman, president, was at the head table with Miss Graham, superintendent of nurses, and the graduating class. Bertha Boyd was in charge of arrangements. The address of welcome was given by Miss Woodman. The toast to the graduating class was given by Wanda Schofield and responded to by Patricia Armstrong. After the dinner, dancing was enjoyed by the nurses and their friends.

Audrey Hodgman has accepted the position of school nurse for Stanstead County. Misses Statton and Elliot have resigned from the staff to be married.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Clinical Supervisor for Medical Ward in new hospital. Experience & post-graduate course required. Good salary. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Night Supervisor at once for new hospital. 8-hr. night. Good salary & week-end leaves. Apply Director of Nursing, Civic Hospital, Peterborough, Ont.

Surgical Nurse (experienced) for permanent position at Hospital for Mental Diseases, Brandon, Man. Salary: $1,980-2,280 per annum, less $300 per annum for full maintenance & laundry. Regular annual increases. 4 wks. vacation with pay annually. Liberal sick leave with pay. Superannuation plan, etc. Apply at once to Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, or to your nearest National Employment Service office.

Surgical Nurse & Supervisor of Reception Unit for Hospital for Mental Diseases, Selkirk, Man. Must be Registered Nurses, preferably with some Psychiatric Nursing experience. Salary: $1,980-2,280 per annum, less $300 per annum for full maintenance & laundry. Regular annual increases, liberal sick leave with pay, 4 wks. vacation with pay annually, pension plan, etc. Apply at once to Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, or to your nearest National Employment Service office.

Senior Instructor of Nursing for Hospital for Mental Diseases, Selkirk, Man. Must be Registered Nurse, preferably with Mental Nursing certificate, capable of supervising educational program for undergraduate & graduate nurses, under direction of Supt. of Nurses. Salary: $2,340-2,940 per annum, less $300 per annum for full maintenance & laundry. Regular annual increases, liberal sick leave with pay, 4 wks. vacation with pay annually, pension plan, etc. Apply at once to Manitoba Civil Service Commission, 247 Legislative Bldg., Winnipeg, or to your nearest National Employment Service office.

Graduate Nurse for permanent position in expanding hospital. Good wages. Full maintenance. Health plan. Good working conditions. Apply Dr. A. R. Penn, 7745 Sherbrooke St. E., Montreal 5, Que. (Phone CLairval 2847).

Matron immediately. Salary: $165 per mo. plus full maintenance. 1 mo. vacation after 1 yr. service. Apply J. J. Reidiger, Chairman, Hospital Board, Freemasons' Hospital, Morden, Man.

Asst. Director of Nursing for 220-bed modern hospital. Teaching experience required. School of Nursing being organized. Modern nurses' residence. Salary open. Apply, stating qualifications in 1st letter, Supt. of Nurses, Jewish General Hospital, 3755 Cote St. Catherine Rd., Montreal 26, Que.

Graduate Nurses for General Duty. Gross salary: $171 with additional $5.00 when registered in British Columbia. Annual increments. Statutory holidays. Good living accommodation & cafeteria service at reasonable cost. Apply Supt. of Nurses, West Coast Hospital, Port Alberni, Vancouver Is., B.C.

General Duty Graduate Nurses for modern 25-bed hospital only 50 miles from Calgary. Salary: $150 plus full maintenance. Straight 8-hr. 6-day wk. Permanent Night Nurse on staff. Apply Nursing Supt., Municipal Hospital, Didsbury, Alta.

Nurses for 15-bed hospital. Salary: $140 per mo. plus full maintenance. 3 wks. vacation yearly. Congenial staff. Separate nurses' home. Good food & working conditions. Unemployment Insurance. New 22-bed hospital under construction to be completed in 8 mos. Magrath is 20 miles south of city of Lethbridge & close to American border. Transportation refunded after 1 yr. service. Apply, stating year & school of graduation, age & when available for duty, Miss L. F. Willows, Supt., Municipal Hospital, Magrath, Alta.

Registered Nurses for Westminster and Sunnybrook Hospitals, London and Toronto, Ont. Salary: $1,920-2,460 plus uniforms. Information & application forms available at Post Offices or Civil Service Commission of Canada. Applications should be filed with the latter at 1207 Bay St., Toronto 5, Ont., as soon as possible.

Public Health Nurses (3) increasing P.H.N. staff to 11 for Township of North York. Pop. 60,000. 5-day wk., sick leave, hosp. ins., pension plan, 4 wks. paid vacation, $720 annual car allowance. Initial salary: $1,900-2,000 with annual increment. Duties to commence Sept. 1 or 15. Apply with full details to Dr. Carl E. Hill, M.O.H., Willowdale, Ont.

Nursing Arts Instructor for 200-bed hospital. 48-hr. wk., 1 mo. vacation annually. Apply, stating qualifications & salary expected, Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ont.

Public Health Nurse for City Health Dept. Salary: $175 per mo. 5½-day wk. Diploma in public health nursing essential. Apply Medical Health Officer, Library Bldg., Saskatoon, Sask.

Associate Director of Nursing for 200-bed hospital. Post-graduate course & institutional experience required. Opportunity for advancement. Apply, stating qualifications & salary expected, Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ont.

Educational Director & Nursing Arts Instructor—immediate openings for Fall term. Hospital is connected with large clinic & located in the capitol city. New addition is being added to hospital this summer. Apply Director of Nurses, Bismarck Hospital, Bismarck, North Dakota.

Supt. of Nurses for new 54-bed General Hospital to open in Nov. This hospital is unique in design & service arrangement & the position offers a challenge in organization for one with the right qualifications. Apply, giving full particulars as to experience, post-graduate study, salary expected, etc., in first letter, to Administrator, Humber Memorial Hospital, Weston, Ont.

Night Supervisor & General Duty Nurses. Apply, stating experience & qualifications, Supt., Queens General Hospital, Liverpool, N.S.

Supt. (qualified) for 60-bed General Hospital. New 125-bed hospital under construction. Apply, giving full particulars & salary expected, G. R. MacQuarrie, Sec., Prince County Hospital, Box 441, Summerside, P.E.I.

Graduate Nurses for small newly built 20-bed District Hospital. Salary: $145 with maintenance. Transportation prepaid if necessary. Apply for further particulars Miss J. E. Knowles, Matron, Municipal Hospital, Mayerthorpe, Alta.

Public Health Nurse for Township of York. Salary: min. $2,000 per annum. Pension plan. Duties to commence as soon as possible. Apply Dr. W. E. Henry, Medical Officer of Health, 1043 Weston Road, Toronto 9, Ont.

Registered General Duty Nurses (2) immediately for interior of B.C. 8-hr. day, 44-hr. wk. with 10 statutory holidays. 1 mo. annual vacation after 1 yr. service or 2 wks. semi-annually, if desired. Sick leave granted: 1½ days per mo. Starting salary: $175 per mo., less $35 full maintenance. This hospital is situated in the heart of the Nicola Valley ranching country. Apply Supt. of Nurses, Nicola Valley General Hospital, Merritt, B.C.

Operating Room Nurse with post-graduate training. $190 per mo., less $35 room & board. Annual increases. 100-bed hospital, 60 miles from Vancouver on Trans-Canada Highway in the Fraser Valley. 44-hr. wk., 28 days holiday after 1 yr., 10 statutory holidays allowed. Apply Director of Nurses, Chilliwack Hospital, Chilliwack, B.C.

Head Nurse to take charge of 35-bed Medical Unit. Post-graduate experience required. 8-hr. day, 88-hr. fortnight. Apply Acting Director of Nursing, Women's College Hospital, Toronto 5, Ont.

Registered Nurses for General Duty Staff. Salary commences at $115 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Surgical Supervisor for Sept. 15. 40-bed ward in 130-bed hospital in Georgian Bay District. Post-graduate or experienced surgical nurse preferred. Good salary with full maintenance. 8-hr. day, 6-day wk. Apply Director of Nursing, General & Marine Hospital, Owen Sound, Ont.

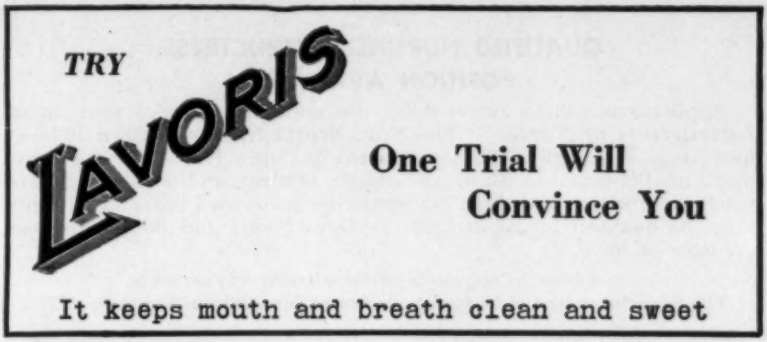
Science Instructor not later than Sept. 1 for 150-bed hospital. 70 students. Apply, stating age, qualifications, experience & religion, Director of Nursing, Public General Hospital, Chatham, Ont.

District Nurses for Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-2,400. Sick leave, annual vacation, pension. Present Cost of Living Bonus — $21 per mo. Apply A/Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.



General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Registered Nurses for General Staff Duty on Rotation Service. Apply, Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Vancouver General Hospital requires **General Staff Nurses.** Salary: $177 per mo. increasing to $207. **Clinical Instructor** — for Surgical Nursing, preferably with experience in General Surgery & Urological Nursing. Salary: $207-232. **Instructor** — preferably with degree as chief subject will be Bacteriology. **Instructor** — preferably with previous experience in teaching & with ward experience. Duties include lectures & demonstrations in nursing arts & allied subjects. Salary: $197-222. Perquisites include: 44-hr. wk. (week-ends free); statutory holidays — 11; vacation — 28 days; sick leave — 1½ days per mo. cumulative; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

General Duty Nurses for 400-bed hospital. New Wing just opening. 8-hr. day, 44-hr. wk. 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience. Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

General Duty Nurses—Medical, Surgical, Pediatrics, Psychiatry, Tuberculosis. Beginning salary: $231 with $10 differential for Pediatrics, Psychiatry, Tuberculosis; also, Evening & Night. 600-bed hospital with school. 40-hr. wk. 8 paid holidays. 3 wks. vacation. Laundry. Accumulative sick leave. Apply Director, Nursing Service, General Hospital, Fresno, California.

Graduate Nurses (2) by Sept. 1 for new modern 20-bed hospital. Salary: $150 per mo. & full maintenance. 8-hr. day, 6-day wk. 2 wks. with pay end of yr. Lively community near U.S. border. English-speaking population. Good climate. Apply P. J. Rasmussen, Sec., Community Hospital, Climax, Sask.

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Applications will be received by the undersigned for a position of ***Instructress of Nurses*** at **The Nova Scotia Sanatorium,** a 400-bed institution, operated by the Department of Public Health for the treatment of Tuberculosis. Both an affiliate student and a post-graduate teaching program have been underway for some two years. Applicants must be qualified for registration in Nova Scotia and have had post-graduate training.

Those interested may obtain further information by writing to:
The Superintendent of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

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Qualified **Laboratory Technicians,** preferably with experience in Serology, for service in various Provincial Centres. Salary commensurate with experience and academic qualifications. All appointments carry Cost of Living Bonus, participating pension, prepaid hospital and medical care, and group life insurance plans.

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Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 48-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $170 less $20 for meals & laundry. $45 deducted if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Also **O.R. Supervisor** with post-graduate experience. State qualifications & salary expected. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

General Duty Nurses for 60-bed hospital. Salary: $140 per mo. plus full maintenance to Registered Nurses; others in accordance with qualifications. Apply Supt. of Nurses, Lady Minto Hospital, Cochrane, Ont.

General Duty Nurses for 50-bed hospital. 8-hr. day, 6-day wk. 4 wks. vacation with pay after 1 yr. service. Salary: $145 per mo. with full maintenance. Apply Ruby W. Ganton, Matron, Union Hospital, Rosetown, Sask.

Director, Personnel Services of the Registered Nurses' Ass'n of British Columbia. Selection will be made on basis of general & professional education, experience & personality. Nurse appointed must be free to travel. Duties to include those connected with labor relations program, personnel practices & placement service. Further information may be obtained from Miss Alice Wright, Exec. Sec., 1101 Vancouver Block, Vancouver, B.C.

General Staff Nurses (2) for hospital in gold mining community in Caribou District. Minimum salary: $175 per mo. R.N.A.B.C. personnel policies in effect After 6 mos. service transportation refunded from anywhere in British Columbia. Apply Placement Adviser, Registered Nurses' Ass'n of B.C., 1101 Vancouver Block, Vancouver, B.C.

Registered Nurses (2) for 21-bed hospital. Salary: $145 plus maintenance & laundry. 8-hr. day, 6-day wk. 4 wks. holiday with pay after 1 yr. service. Apply Matron, Union Hospital, Cabri, Sask.

CANADIAN RED CROSS SOCIETY

invites applications for **Administrative** and **Staff** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

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For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society,
95 Wellesley St., Toronto 5, Ontario.

ASSISTANT SECRETARY-REGISTRAR

Applications are invited for this position by ***The Association of Nurses of the Province of Quebec.***

For further particulars write to:

The Secretary-Registrar,
The Association of Nurses of the Province of Quebec,
Room 506, 1538 Sherbrooke St. W., Montreal 25, Que.

Supt.-Administrator for Memorial Hospital, Trenton, Ont. 70 beds, 17 cubicles. Absolutely new hospital. Immediate employment Apply S. O. Graham, Sec.-Treas., Board of Directors.

General Duty Nurses (4) for 35-bed General Hospital, 50 miles north of Toronto. Straight 8-hr. duty. Salary: $130 per mo. For further information write Supt., Lord Dufferin Hospital, Orangeville, Ont.

Registered Nurses for General Duty. Salary: $145 per mo. plus full maintenance. 3 wks. holidays with pay per yr. Apply Matron, Municipal Hospital, Wainwright, Alta.

Supt. of Nurses for 320-bed Sanatorium for Tuberculosis. Initial gross salary between $225-250 depending on training & experience. 44-hr. wk. 3 wks. holidays. Optional pension plan. Expenses paid to one nurses' meeting per yr. Newly built & furnished suite with bath. Garage available. Asst. Supt. also employed. Apply, giving qualifications, references, etc., Medical Supt., Fort William Sanatorium, Fort William, Ont.

Operating Room Nurses. Post-graduate training not essential. All-graduate staff. 8-hr. day 44-hr. wk. Apply Director of Nursing, Children's Memorial Hospital, Montreal 25, Que.

Registered Nurses for General Duty at St. Michael's General Hospital, Lethbridge, Alta. Initial salary: $1,800 per annum plus $180 cost of living bonus payable annually. Statutory holidays. Sick leave. 2 wks. holiday after 1 yr. continuous service increasing to 3 wks. in 2nd year. Blue Cross coverage on a 50% employee contributory basis. 1st class railway fare to Lethbridge refunded after 18 mos. continuous service. Apply Administrator.

Director of Nursing for large General Hospital with School of Nursing, averaging 150 students. Correspondence invited. Apply, giving full details of education, post-graduate training, experience, references, etc., c/o Box 50, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

General Duty Nurses for 60-bed General Hospital. Salary: $115 plus full maintenance. 3 wks. vacation per yr. Apply, giving full information, Supt., Public Hospital, Smiths Falls, Ont.

Public Health Nurses for School Division, Calgary City Health Dept., Alberta. Salary schedule: $187.82-222.82 over 5 yrs. Pension plan. 5-day wk. 1 mo. vacation with pay after 1 yr. service. Apply Supervisor of Nurses, Health Dept., City Hall, Calgary, Alta.